

# Clinical Psychology

Issue 33 January 2004



**Assertive Outreach**  
**User involvement in training**  
**Who gets into debt?**

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

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

#### Copy

Please send all copy and correspondence to the Co-ordinating Editor: Craig Newnes, Field House, 1 Myddlewood, Myddle, Shrewsbury SY4 3RY; fax: 01939 291209; e-mail: craignewnes@aol.com; website: www.shropsych.org

#### DCP Update

Please send all copy to: Simon Gelsthorpe, CRST, Daisy Bank, 109 Duckworth Lane, Bradford BD9 6RL; e-mail: hermanewtix@hotmail.com

#### Book Reviews

Please send all books and review requests to: Arlene Vetere, Department of Psychology, Surrey University, Guildford GU2 7HX

#### Advertisements

Advertisements not connected with DCP sponsored events are charged as follows:

Full page (20cm x 14cm): £140

Half page (10cm x 14cm): £85

Inside cover: £160

All these rates are inclusive of VAT and are subject to a 10 per cent discount for publishers and agencies,

and a further 10 per cent discount if the advertisement is placed in four or more issues. DCP events are advertised free of charge.

The Society's Terms and Conditions for the acceptance of advertising apply. Copy (preferably camera ready) should be sent to: Jonathan Calder, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR; Tel: 0116 252 9502 (direct line); Fax: 0116 247 0787; joncal@bps.org.uk.

Publication of advertisements is not an endorsement of the advertiser, nor of the products and services advertised.

#### Subscriptions

Subscription rates for *Clinical Psychology* are as follows:

UK (Individuals): £30    UK (Institutions): £60  
US only: \$160    Outside US and UK: £80

Subscriptions should be sent to: Clinical Psychology, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR; Tel: 0116 254 9568; Fax: 0116 247 0787

*Clinical Psychology* is published monthly and is dispatched from the printers on the penultimate Thursday of the month prior to the month of publication.

### Submitting to *Clinical Psychology*

- Articles of 1000—2000 words are welcomed. Send two hard copies of your contribution.
- When sending copy, make sure it is double spaced, in a reasonably sized font and that all pages are numbered.
- Give a 40-word summary at the beginning of the paper.
- Contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e. avoid clustering terminology like 'the elderly' or medical jargon like 'person with schizophrenia'. If you find yourself using quotation marks around words of dubious meaning, please use a different word.
- Articles submitted to *Clinical Psychology* will be sent to members of the Editorial Collective for refereeing. They will then communicate directly with authors.
- We reserve the right to shorten, amend and hold back copy if needed.
- Include a word count at the end (including references).
- Spell out all acronyms the first time they appear.
- Include the first names of all authors and give their employers, and remember to give a full postal address for correspondence.
- Give references in *Clinical Psychology* style, and if a reference is cited in the text make sure it is in the list at the end.
- Don't include tables and figures unless they save space or add to the article.
- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.

# Clinical Psychology

Issue 33 – January 2004

<b>News</b>	3
<b>Correspondence</b>	5
<b>Articles</b>	
<b>The experiences of clinical psychologists in Assertive Outreach</b> Kevin Yates	8
<b>Hand in hand: user and carer involvement in training clinical psychologists</b> Christine Curle and Annie Mitchell	12
<b>Providing an anger management service through psychoeducational classes – and avoiding therapy</b> Simon O'Loughlin, Julie Evans and Jo Sherwood	17
<b>To attend or not to attend: 'seasonal' and school term influenced variation in non-attendance rates at a CAMHS outpatient clinic</b> Lynne Taylor and Rachael Smith	21
<b>The Outlook summer group: a social skills workshop for children with a different appearance who are transferring to secondary school</b> Lynn Maddern and Tina Owen	25
<b>A sign of our times: clinical psychologists' awareness, concerns and interest in supervising a deaf trainee</b> Alexandra Dent and Rachel Atherton	30
<b>Debt: Who gets into it, who gets out of it and what can clinical psychology do to help?</b> Clare Wright	35
<b>Book Cover</b>	42
<b>Columnists</b>	
<b>Self-help</b> Felix Q.	47
<b>The Alternative Page</b> Nigel Mills	48

# News

## NHS drug bill continues to rise

The annual total of drugs prescribed in the National Health Service has risen by 17 per cent in the last three years.

Sir Nigel Crisp, the chief executive of the NHS, revealed the figures in his annual report, which was published on 3 December. In 1999-2000 541m prescriptions were given out, and in 2002-3 the figure rose to 632m. The cost of drugs rose even more steeply, with this year's expenditure of £7.13bn being 49 per cent higher than the equivalent figure three years ago.

Asked if the NHS was getting good value for this money, Sir Nigel said: 'That is a good question. We are in negotiation with the drug industry over where we are going with the pharmaceutical price regulation scheme.'

The report also shows that the number of patients treated by the NHS continues to rise. Non-urgent hospital admissions and treatment by GPs and in outpatient clinics have all risen in the last three years.

Meanwhile, waiting lists have declined. The number of patients waiting for over a year has fallen from 16,689 in September 2002 to 114 in September this year.

## Research not to be sneezed at

Happy, relaxed extroverts with active lives are least likely to catch the common cold, according to research carried out by a Pittsburgh psychologist. Sheldon Cohen from Carnegie-Mellon University has been exposing volunteers to cold by dropping rhinoviruses into their noses and then quarantining them for five days to see if they become ill.

A report on the USA Today website says that Cohen's findings from medical tests and questionnaires suggest the following:

- adults with the worst scores for calmness and positive mood are three times more likely to catch colds than the most relaxed and contented people and when the latter do fall ill, their symptoms are milder;

- the more extroverted people are, the less likely they are to catch cold;

- serious work-related or personal stress for at least a month increases the chances of catching a cold, and the longer people have lived with that stress, the more likely they are to catch cold;

- playing diverse social roles, such as spouse, parent, worker and club member, improves resistance - those with three or fewer roles were four times more likely to catch cold than those with six or more.

## From Catterick to the Priory

The army is to close its last remaining psychiatric hospital and has signed a contract for the Priory Group to provide in-patient services for service personnel. The Duchess of Kent's Psychiatric Hospital at Catterick, North Yorkshire, is to close by 31 March 2003, when the full transfer of in-patient care to the Priory Group, which is best known for its celebrity clients, will take place.

Ivor Caplin, junior defence minister, announced the move in a written statement on 2 December 2003. He described it as 'part of the Ministry of Defence strategy to modernise and improve Defence mental health services' and said: 'The awarding of this contract should be seen as part of our wider strategy to improve healthcare for Service patients by reconfiguring mental health services to be community focused with the emphasis on local provision.'

## Worrying about Hurried Women

The *Chicago Sun-Times* has reported the discovery of a new medical condition: Hurried Woman Syndrome.

Dr Brent Bost, a Texas-based obstetrician and gynaecologist, lists its symptoms - fatigue, weight gain, low sex drive, moodiness - in his book on the syndrome and claims that it affects women in 'epidemic proportions'. He estimates that 50 million women in the United States are sufferers.

# Correspondence

## ✉ Training in Australia

It was good to read an article from Australia by Vaughan Parsons (CP31). After working as a clinical psychologist and co-ordinating a postgraduate clinical training programme in the UK, I have been fortunate enough to work for nine years in Australia, both in university and field settings. I agree with Vaughan Parsons' conclusion that it might be timely for the BPS to look again at its position on equivalence, to allow well-trained clinical (and forensic) psychologists easier access to positions in the UK.

I disagree, though, with his account of in-service training and the implication that this level of training is appropriate or equivalent to postgraduate clinical training in the UK (or Australia). The policy of the Australian Psychological Society is that applied psychologists should be six-year trained (four years' undergraduate/Honours plus two years' Masters course). My experience is that graduates from Australian Masters courses are very similar in knowledge and skills to those who graduated from two-year Masters courses in the UK, prior to the three-years requirement. Often Australian postgraduates have better research skills than their UK equivalents because of the substantial nature of the research thesis in the Honours year.

The in-service 'internship' (the term is not used in all States) is a very different beast from Masters-level training. In my view it is equivalent to pre-Masters 'apprenticeship' training in the UK in the 1950s and 60s. Although many excellent individuals train in this way, in effect they have had little or no systematic exposure to the extensive theoretical and empirical body of knowledge that constitutes contemporary clinical psychology. I think it inevitable that Australian states will move to the Masters as the minimum requirement for registration - hopefully soon.

Overall, I find standards of university training here very similar to those in the UK and would encourage UK employers to take on well-trained applicants (Masters and doctoral level) from Australia. Many of the latter have already made

important contributions to clinical psychology in general and to clinical services in the UK in particular.

As an aside, postgraduate training in forensic psychology is extensive, growing rapidly and of a high standard in Australia. These graduates have much to offer to forensic services.

## Kevin Howells

Professor of Forensic Psychology, University of South Australia

## ✉ Anxieties and memories

We would like to respond to the article 'Have you got children of your own' (CP30), which we found interesting and thought provoking. We have often considered what influence having children of your own has on your practice. One of us has children and the other has not. Some points we would like to expand on include feeling more empathy when you have children of your own, the different backgrounds of clients and sharing personal experiences.

The authors felt having children themselves had given them more 'empathy' when working with parents. Empathy is the ability to understand and feel what someone else is feeling by entering into their world, using their frame of reference not our own. This suggests that the authors may feel more sympathy for the parents due to their personal experiences. Whether or not you have children yourself, the one thing we all have in common is the ability to empathise with a child, because we have all been children ourselves. When parents are able to empathise with their children, they have a better understanding of the child's perspective and are therefore in a good position to help resolve any difficulties. However, for many parents experiencing significant pressure from external factors (economic, social and past history), it can be difficult to find space to think about their child's experience.

In Middlesbrough we have been applying the Solihull Approach in much of the clinical work

that we do. In this there is considerable emphasis on containment and reciprocity, which minimises the influence of personal experience without completely denying its impact. Often, the clients that we are dealing with have very different life experiences from our own, and their children are being brought up in circumstances quite different to those of our own children. Therefore the demands placed on these children are different and their behaviour requires different management. In this situation whether you have children or not is not particularly relevant. The ability to contain anxiety and to build a reciprocal relationship is of greater significance.

The authors felt not having children could give you a distance from the families' difficulties and that an individual's personal experiences are not detachable. If personal experiences are not detachable then it's important to consider everyone's personal experiences whether or not they have children. Clients we have worked with previously and experiences in our own childhood and families may then also impact on our work.

We think it is interesting to reflect when we feel it necessary to share personal experiences, are we doing it for the clients benefit or our own? Is it our own anxieties and memories that lead us to share personal experience and how helpful is this to the family considering where they are at and their background?

**Alison Pritchard and Laura Robson**

Child and Family Psychology, Primary Care, Middlesbrough

✉ **Older adults – complex needs**

In the Tameside & Glossop Mental Health Service for Older People myself and other key professionals have recently set up a steering group to look at the service that we offer to older people with complex needs. In our case we define this as people who:

- are difficult to engage;
- display a range of mental health problems;

## **Private Consulting Rooms to Let Hampstead, London NW3**

Sessions are available in new consulting rooms for psychologists. Availability is seven days a week and with flexible times. Situated in Hampstead Village, within walking distance of Hampstead and Belsize Park Underground Stations, several bus routes, Royal Free Hospital and Tavistock Clinic. Competitive rates.

Contact Professor Robert Bor: 07768 890388.

- exhibit various impulsive or risky behaviours;
- often have chronic difficulties;
- may have been diagnosed with a personality disorder.

We would be interested in hearing from anyone who has developed care pathways, assessment and intervention protocols or other systems for working with this client group.

**Catherine Gartside**

Chartered Clinical Psychologist, Ashton Under Lyne; catherine.gartside@penninecare.nhs.uk

✉ **Mandatory CPD**

I am writing to state that I am fully supportive of mandatory CPD, and have very few problems with the proposals currently. The one serious difficulty I have is with who this requirement applies to. At the moment, it will apply to all Chartered Psychologists, as I understand. It is my experience that very few psychologists are Chartered; certainly, where I work the vast majority of staff are not Chartered.

Ms Harris (CP30) goes on to state mandatory CPD is a way that 'the Society ensures the protection of the public'. I cannot see how this can be done without some *real* action on the requirement to be Chartered. Chartered psychologists are already the people who have to pay fees etc. to the Society but receive few (if any) benefits for this. Certainly there appears to be no commitment from this particular NHS Trust to address this issue proactively. Other issues around this relate to who has the right to refer to themselves as clinical psychologists.

If this will be changing, what will these changes be? I know of several people who are referring to themselves as a 'Consultant Clinical Psychologist' without being Chartered. How and when will clarity around these issues become available?

I am of the opinion that all people referring to themselves as 'psychologists' should be required to register with the Society, and be subject to the same expectations as Chartered Psychologists. Mandatory CPD (and its proposed link with practising certificates) will be much more palatable once this clarity has been obtained. I would sug-

gest that it becomes mandatory for the profession and Trusts to commit to a 'cleaning' up process. Discussions with private insurers and input about what the minimum requirements for the use of the term 'psychologist' entails, should go a long way towards a meaningful 'agenda for change'.

In this way I believe that most of us will feel that there is real support from the Society in efforts to protect the recipients of our services.

**J. S. Pieterse**

Chartered Clinical Psychologist

# DCP Annual Conference 2004

**15-17 April 2004;**  
Imperial College, London

## *Call for Poster Submissions*

Poster submissions are welcome on any subject relevant to clinical psychology. Guidelines and forms are available from the Society's website ([www.bps.org.uk](http://www.bps.org.uk)) or from the Society's Conference Hotline (0116 252 9555).

If you would like an informal discussion with the Chair of the DCP Conference Subcommittee before submitting your work, please contact Steve Jones at [SJones@fs1.with.man.ac.uk](mailto:SJones@fs1.with.man.ac.uk).

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

# The experiences of clinical psychologists in Assertive Outreach

Kevin Yates, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust

*This article reports some of the findings from a survey that I carried out amongst 34 psychologists from the Network of Psychologists in Assertive Outreach.*

Traditionally it has been difficult to recruit psychologists to rehabilitation services for people with severe and enduring mental health difficulties. This is unfortunate, since the reinforcement of psychological thinking within teams would seem central to realising truly psychosocial or biopsychosocial interventions. The nature of therapeutic endeavours within teams tends to gravitate to what people know and are familiar with, particularly in times of crisis when practice seems to be influenced more by biomedical conceptualisations. As a psychologist working in an Assertive Outreach (AO) team, an important part of my role is to routinely encourage myself and colleagues to evaluate some of the assumptions that underlie our clinical work. Central to this is the task of challenging (either subtly or directly) some of the dominant narratives about aetiology and prognosis of disabilities. Biomedical theories tend to dominate, with a substantial emphasis on compliance with medication, but in my service team members strive to deliver evidence-based psychosocial interventions.

For those readers who are unfamiliar with AO, it is a service model that was developed in the USA. AO explicitly aims to support people with whom other services have been unable to sustain engagement (primarily people with an enduring experience of 'psychosis' or significant interpersonal difficulties). Like many other CMHTs, AO emphasises the importance of supporting families, managing resources and providing a range of effective treatments outside the hospital system. The most salient differences between AO and con-

ventional CMHTs, however, are a high staff to client ratio (ideally 1:10), a 'whole-team' approach where case management for each client involves the whole team, daily morning handovers, out-of-hours and weekend cover, an indefinite period of support for clients and an explicit requirement for professionals to work both as a specialist and as a generic team worker. Generic work in this context means engaging with clients in social, occupational and practical pursuits.

If NHS targets are met, 220 AO teams will have been set up in England by the end of 2003, and it would be encouraging to think that each one had a psychologist within its ranks or at least access to clinical psychology. Already there are a significant number of psychologists in AO. At the inaugural meeting of the Network of Psychologists in Assertive Outreach there emerged clear themes about the advantages and challenges reported by people about their work, some of which seemed common to working in any team and some specific to AO.

This article reports some of the findings from a survey that I carried out amongst 34 psychologists from the Network of Psychologists in AO. Using a modified Delphi methodology, the main task of colleagues was to report the range of advantages and challenges they felt were relevant to working in an Assertive Outreach Team. For a summary of methodology and a fuller report of the results, please contact the author.

## Activities of AO psychologists

To varying degrees, psychologists working in AO have the opportunity to engage in a range of activities. Most people surveyed provided direct clinical interventions for people with complex needs. Other activities included group work, research and audit, supervision, service development, teaching, consultation and management.

## Advantages for AO psychologists

At meetings of the Network, it has always been clear that AO psychologists are enthusiastic about their work. All respondents to the survey identified the opportunity of working in a new and innovative area as an advantage. In terms of specific aspects of the job, advantages included the promotion of psychological and person-centred understandings of individuals, the development and delivery of psychological interventions, and the opportunity to form long-term trusting relationships with clients to make psychological interventions an accessible and credible option. Members of the Network expressed a sense that these characteristics had been significant in motivating them to consider working in this area in the first place. AO work also enables members to work within their own special interest, primarily working with people who have complex needs and (primarily) people who have been diagnosed with a psychosis.

## Challenges for AO psychologists

### *Experience*

Perhaps one of the most striking findings from the survey was that the modal length of time that members of the Network had been qualified was one year, about half being qualified for two years or less. Given the newness of the AO model and the challenges inherent in working within a developing service, it would seem appropriate for team members to be reasonably experienced and confident in what they do, regardless of profession. I took my own AO job as a newly qualified psychologist and have experienced many of the challenges shared by colleagues. The difficulty of balancing different aspects of the job, for example, comes partly from the fact that I, like all but three of the Network psychologists, am employed in a split post. However, this difficulty is also exacerbated by the model of AO which explicitly requires team members to work as both a specialist and generalist. Perhaps it is not surprising that nearly all colleagues who were surveyed reported role confusion as a difficulty. However, since so many of my colleagues were, like me, newly qualified when they took up their posts, these findings may merely reflect the experience of people in their first job rather than of working in AO *per se*. However, the challenges identified

were also endorsed by the more experienced Network members, some of whom had been qualified for 23 years.

Most of the members of the Network reported that they worked within a dominantly psychiatric system. This was experienced as both a positive challenge and as a source of frustration. From my own experience, biomedical formulations often 'trump' psychological understandings of clients' experiences and at worst compromise efforts to do psychological therapy. However, this aspect of the work continues to challenge me and has been a factor that has motivated me to stay in the job.

### *Hours of work*

About a third of people worked outside normal office hours. On the whole, working out of hours was felt to be a disadvantage; however, this aspect of the job attracted a high level of ambivalence among Network members. Given the quality of the lives of many of our clients with whom traditional services have not been able to engage, my own experiences have suggested that the style of AO working (including out-of-hours and generic working) provides opportunities to carry out psychological assessments, to develop psychological formulations of people's experiences and to intervene and deliver psychological therapy in less traditional and more creative ways. This is, perhaps, the innovative approach that psychologists in AO identify as a significant pull to the job. From the findings of the survey, it seemed that the downside of working in less traditional ways is, at times, a feeling of a reduced clarity of role and a perception of an underuse of clinical skills.

### *Team working*

Psychologists reported both advantages and challenges of working in a team environment. For an interesting take on the challenges of working in teams, Guy Holmes provided an account of his experiences of working in CMHTs (Holmes, 2001). For the Network, psychologists felt that, overall, the advantages of being supported (and often challenged) by colleagues from other professions, by colleagues without formal qualifications and from users outweighed difficulties, particularly within a whole-team approach when it was working well.

### *Care co-ordination*

Half of the group were expected to take on a care co-ordinator role for clients. I am a care co-ordinator within my team and, in the context of the whole-team approach this seems appropriate. However, this is a new role for psychologists and I am aware that many colleagues are ambivalent about this role since in itself it holds both advantages and challenges to engaging in a therapeutic relationship with clients. It is beyond the scope of this article to discuss this in any depth here; I suspect this will be a topic discussed further within the Network.

## **Challenges for managers**

### *Support*

The service within which I work hoped to recruit a psychologist with three or four years' post-qualification experience, and after 18 months in my post I can see why. As a newly qualified psychologist when I first took the job, I was struggling with what seems now to be an inevitable uncertainty about what I knew and what I had to offer. Perhaps the large number of new psychologists working in AO represents the difficulty in attracting experienced psychologists to work in rehabilitation services. Whatever the reason, managers need to be aware that posts currently being advertised may well be filled by inexperienced and vulnerable people. It seems that, compared to some members of the Network, I have been fortunate in receiving a high level of support from senior colleagues, whereas others have felt quite isolated. Network discussions have highlighted the need for structured support and supervision for AO psychologists, not just those newly qualified but for all working in this new area for psychology.

### *Training*

A large proportion of AO psychologists perceived a lack of training. Although the survey did not provide any detail about specific difficulties in this respect, themes around multidisciplinary working and specific psychological interventions for people diagnosed with psychosis were identified as areas of need. As a large proportion of psychologists may be expected to be care co-ordinators, it is also important to ensure that the appropriate training is available.

### *Working outside traditional hours*

Since those psychologists who worked out of hours identified advantages to this type of working (as well as disadvantages), it might be valuable for other AO psychologists to work outside traditional office hours. Again, this is likely to be a controversial topic, as not all colleagues would advocate unconventional working practices. However, if a need is identified and the psychologist wishes to work as much as possible in line with the whole-team approach, then procedures need to be developed to reward out-of-hours work. Only two psychologists received extra pay for working out of hours and this was achieved by negotiating additional spine points. However, within the new NHS pay system Agenda for Change it may be easier in the future to make arrangements to recognise different working patterns and to reward working outside normal hours appropriately.

## **Challenges for the profession**

Our profession has recognised the contribution that psychology and psychologists can make to services for people with enduring mental health difficulties (BPS, 2000). Further, the BPS, primarily through the efforts of people like Peter Kinderman, has taken an active role in contributing to the process of responding to proposed Mental Health Act reforms, within which the role of the AO psychologist may change profoundly, for example as clinical supervisor. As AO is one of the new mental health services, along with Early Intervention and Crisis Resolution Services, it seems vital that psychologists take an active role in the continuing development and provision of services for people with severe and enduring mental health difficulties. The profession should therefore be aware of the importance of recruiting psychologists to services such as AO.

## **Final comments**

It is within special interest groups such as the Network that psychologists can potentially obtain a critical mass to influence and shape service policy and service delivery. Within the Network it seems clear that there is no single model of AO in this country, despite initial aspirations to adhere to an American evidence-based service model. This is, perhaps, no bad thing, since we are discovering

that Assertive Outreach in the UK has some fundamental differences to the original American model of Assertive Community Treatment, not least in its emphasis on multidisciplinary work.

The group of psychologists who work in AO are dedicated and enthusiastic about their jobs. They are working in a new and innovative area, are challenged by complex clinical work, are dealing with both the advantages and challenges of working in a team and, for the most part, are coming to terms with role confusion and a potential identity crisis. I have realised that my skills are there to be exploited in every interaction with the team, with individual team members, with clients and within wider systemic layers. By offering an alternative to a dominant psychiatric view and by facilitating clinical reflection, I feel I am making changes and that I have learned to be realistic about the pace and size of that change. Although not perfect, the whole-team approach of AO engenders willingness on the part of team

members to work together and take on different roles for every client and it is here that I think we can be most influential.

The Network of Psychologists in Assertive Outreach currently has 58 members and meets twice a year. If there are any psychologists who would like to join the Network or who are interested in finding out more about working in Assertive Outreach, please contact me by e-mail at the address below.

### References

British Psychological Society (2000). *Recent Advances in Understanding Mental Illness and Psychotic Experiences*. Leicester: BPS.

Holmes, G (2001). So, farewell then CMHTs. *Clinical Psychology*, 6, 7–10.

### Address

Department of Psychological Services and Research, St George's Hospital, Morpeth, Northumberland NE61 2NU; kevinmyates@hotmail.com

# Guide to DCP Publications

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

[www.bps.org.uk/documents/dcppublications.pdf](http://www.bps.org.uk/documents/dcppublications.pdf)

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**

# Hand in hand: user and carer involvement in training clinical psychologists

Christine Curle and Annie Mitchell, University of Exeter

*NHS policy requires patient and public involvement in all aspects of service provision, including training of professionals. We describe how we set up a user and carer advisory group to the Exeter Doctorate in Clinical and Community Psychology.*

We are all learners – don't want professionals who lord it over you – the problem is with all professionals who put themselves above themselves.

*User Advisory Group member, Exeter, 2002.*

As trainers it is too easy to become distanced from real people, real distress and the complex worlds we all live in. Setting up a user advisory group has reminded us that we are all potential service users and keyed us into what matters to us all when we need help: mutual respect, humanity, trusting relationships and achieving some control in our own lives. We are aware of the debate about the best words to use to refer to people who use services. We have chosen the term 'users' to include patients, users, clients and carers. It is important to acknowledge that we all may be users, therefore we have tried to use the inclusive terms 'we' and 'us' wherever possible.

## Why now?

The modernisation agenda requires a change to the culture of the NHS to 'shift the balance of power towards patients' (DoH, 2000; 2002). To achieve this we must begin with training, so that new professionals are socialised into partnership approaches to clinical work. The Department of Health therefore requires that

those involved in professional training should

ensure increased emphasis on the value of service users as teachers in all basic training;

and

Service users are involved more in curriculum design and in assessment and (working with professional bodies) compulsory assessment of communication skills, partnership skills and ethics (DoH, 1999: 7).

The document *A Health Service of All the Talents: Developing the NHS workforce* requires that the needs of patients are made central to workforce development and notes:

an over-academicisation of basic training with a selection process which emphasises academic ability over caring skills (DoH, 2001: 11).

An unpublished study (Jellico-Jones, 1997) indicates possible resistance to the idea of user involvement in clinical psychology training. Her survey of 25 clinical psychology programmes found a discrepancy between trainees' and programme organisers' views about service-user involvement in training, with the latter identifying more disadvantages and fewer advantages than the former.

Goodbody (2003) and Harper and Goodbody (2003) convey the complexity of the issues involved in two articles based on a workshop on 'user-involvement in training' held at a conference of the Group of Trainers in Clinical Psychology. They note issues of power and inequalities, dangers of professional defence of the status quo and the potential richness of the multiple voices and perspectives that may be opened up through seeing user involvement as a process that cuts

across teaching, placements and research in clinical training.

Our emphasis on community psychology and social inequalities at Exeter has led us over many years to engage with service users as teachers who can convey their perspectives and life experiences in a way in which trainees are enabled to see potential clients as effective and resourceful figures. We try to ensure that users or carers contribute to all client group teaching. A natural development of that work was to invite these people to join some of us from the programme team (clinical director, academic director and programme administrator) to form a user advisory group that could potentially have an influence beyond the impact of individual teaching slots.

### Setting up the group

We invited all service users who had recently taught on the programme to come to a series of three meetings at a time when we were making major changes (we were expanding, modularising the programme and preparing for the new BPS accreditation criteria). We felt that at this time of change there was a real opportunity for users' views to actively influence the programme. The plan for the three meetings was to introduce ourselves, share experiences of teaching and for us to explain what help was needed; for users and carers to come back with their thoughts and ideas; and finally, for us to let them know how we had used their suggestions.

Members were clear that they wanted:

- informal meetings with facilitators rather than a chair;
- notes rather than minutes;
- equal contributions to the agenda;
- flexible attendance without a feeling of obligation;
- travel and carer expenses, but not a fee;
- a lunch with social time together;
- feedback about the impact of their input.

### The first three meetings

Membership of the group comprised three parents of children who use psychological services and six people (including an older person) who between them use services for learning disability, head injury, physical disability and adult mental health.

We tried to create an atmosphere that was both relaxed and respectful. We agreed some shared rules to try to ensure that the meetings were friendly, comfortable, safe and useful. We began by sharing personal experiences as service users and carers; we were explicit that we know that any one of us can both receive as well as give care.

### Ideas generated in early meetings

In the first meeting the users and carers generated a list of good and bad qualities in a clinical psychologist. They saw these as applying equally to all health and social care professionals. The results are given in Tables 1 and 2.

Other key issues raised were:

- training programmes should find ways to enable trainees to see things from users' points of view;
- users should be involved in selection;
- users should contribute to assessment of trainees' performance;
- users expected that trainees would be observed routinely by their supervisors;
- users hoped that clinical psychologists would play a part in ensuring healthcare is flexible, respectful and responsive to circumstances;
- users emphasised the need to know what to expect in clinical sessions especially in relation to planning for endings,
- the complexity of gaining consent when client work is written up for academic purposes, with an emphasis on work being written up respectfully and humanely,
- a recognition that users do not speak with one voice and that there will be disagreement and debate on some issues.

**Table 1.** Good features in a clinical psychologist

1.	Immediately friendly, warm and understanding
2.	Available and gives a feeling that you have their full attention
3.	Offers real, practical and genuine support
4.	Understands the constraints of your situation
5.	Hears/accepts what is said
6.	Open to learning from the client
7.	Perceptive of good working relationships
8.	Engages in two-way understanding
9.	Honest, transparent, reflective, sensitive and trustworthy
10.	Credible in their profession, with relevant experience and track record of having dealt with people with similar conditions
11.	Does their homework
12.	Liases with other professionals before and after work with clients

**Table 2.** Bad features in a clinical psychologist

1.	Lack of eye contact
2.	Weak handshake
3.	Patronising
4.	Lack of time/attention
5.	Hear but not listening
6.	Arrogant
7.	Having all the answers
8.	Unable to recognise the client's own resources

**Impact of the group**

The programme team has listened to the views of the advisory group and we have been able to feed back the following changes:

- a greater emphasis on user centred values within the programme specification;

- user involvement in selection;
- including the list of 'good and bad qualities' in the programme handbook;
- a new requirement that supervisors base their assessment both on direct observation of trainees' work, and on direct feedback from users;
- new guidelines on consent and confidentiality;
- addressed some omissions highlighted by users in teaching sessions;
- input about service user perspectives at supervisor training events;
- formally feeding users' views into the programme meetings
- facilitators feeling empowered by the user group to advocate more strongly about issues of power and inequalities within the programme.

**Development of the group**

By the second meeting members felt that the group was sufficiently valuable for it to continue following the same structure and process. The group now meets four times a year. Meetings are scheduled so that themes arising can be fed into clinical psychology training committee meetings. Service users do not want to attend formal meetings, so their views are represented by the facilitators. However, the constitutions of the meetings enable them to be formally present in future if they choose.

The user group made a lively presentation at a supervisor conference. Supervisors said that this brought the conference to life and reminded them of the value of putting users at the heart of our thinking.

**Reflections from the group facilitators**

It is a privilege to work with users in this way. We have felt humbled by their passion and commitment to contribute to services that have sometimes served them well, but at other times let them down. This work keeps us grounded

and stops us overlooking the human aspects of training which can sometimes get lost in formal and academic bureaucracy. We see this work as going some way to combating the socialisation phenomenon that users have so often described to us whereby they are impressed by the humanity, enthusiasm and freshness of trainees at the outset of training and dismayed that they seem to lose these qualities through the process of training. Potential benefits include increased mutual respect, reduced sense of 'them and us', greater acknowledgement of emotional issues and vulnerability, more incorporation of users' understandings and social context issues into mutually agreed formulations, users and carers taking more power in service provision, and negotiation about sustainable and realistic expectations of what health and psychological care may offer.

This work is not without its challenges. Attending meetings regularly, sharing feedback on documents, negotiating differences, finding ways to integrate that feedback and supporting one another between meetings is time consuming and can be unsettling. The thorny issue of representativeness is often raised as a barrier to setting up groups like this. We believe that no one service user or carer is representative of all service users and carers, just as we are not representative of all members of our profession in a statistical, democratic or typical sense. We do need to find equitable ways to ensure that a full range of voices is heard. We need to listen to what users and carers say, to take action where possible and to acknowledge the limits to our sphere of power and influence.

### Acknowledgement

Thanks to the members of the Service User Advisory Group for giving freely of their time and commitment, for reading and commenting on drafts of this paper, and for suggesting the title.

### References

Department of Health (1999). *Patient and Public Involvement in the New NHS*. Leeds: Department of Health.

Department of Health (2000). *A Health Service of all the talents: Developing the NHS workforce*. Leeds: Department of Health.

Department of Health (2002). *Shifting the Balance of Power: Next steps*. Leeds: Department of Health.

Goodbody, L. (2003). On the edges of uncertain worlds: People who use services, clinical psychologists and training. *Clinical Psychology*, 21, 9-13.

Harper, D. & Goodbody, L. (2003). Involving users of services in clinical psychology training. *Clinical Psychology*, 21, 14-19.

Jellicoe-Jones, L. (1997). Service user involvement in clinical psychology training. Unpublished project, University of Manchester.

### Address

Doctorate in Clinical and Community Psychology, School of Psychology, Washington Singer Building, Perry Road, University of Exeter, Exeter EX4 4QG

**British Psychological Society  
Wessex & Wight Branch** in  
collaboration with the **Trust for the  
Study of Adolescence**

## **Working with young people: Translating research into practice**

**Wednesday 28 January 2004;**  
University of Sussex, Brighton

This conference is aimed at researchers, psychologists, practitioners, students and anyone with an interest in applying psychological research to work with young people

*For more information please  
contact: Rosie Meek on 01273  
606755 ext. 2395 or  
r.meek@sussex.ac.uk*

# Providing an anger management service through psychoeducational classes – and avoiding therapy

Simon O'Loughlin, Julie Evans and Jo Sherwood, Kidderminster Department, Worcestershire Mental Health Partnership NHS Trust

*Those referred with anger management problems are notoriously difficult to help, either individually or in therapy groups. The clinical psychology department at Kidderminster set out to provide brief, mixed-gender, psychoeducational classes on anger management, inviting up to 30 people at a time, to teach theories about anger and techniques for managing anger more creatively; 'therapy' was specifically avoided. The development of the programme is discussed, with experiences from the first eight groups over a two-year period.*

Problems of managing and controlling anger are evident in our society, often resulting in psychological, social and relationship difficulties (Cornell, Peterson & Richards, 1999; Deffenbacher, Oetting, Lynch & Morris, 1996; DeMoja & Spielberger, 1997; Greene, Coles & Johnson, 1994; Jacobson et al., 1994; Whiteman, Fanshel & Grundy, 1987).

Clinical psychologists are well placed to help with these problems. Local departments often offer a range of psychological approaches, both group and individual (Munro & Macpherson, 2001). Mayne and Ambrose (1999) provide evidence that Cognitive Behaviour Therapy (CBT) is an effective intervention, both in group and individual settings (see also DiGiuseppe & Tafrate, 2003). Psychoeducational approaches, rather than therapy, have been examined (White, 2000).

Research suggests that there are inherent difficulties encountered while working with people with specific anger problems. Low attendance is often cited as one such difficulty (Valliant & Raven, 1994; Hird et al., 1997; Anderson-Malico,

1994). Research has rightly focused on those factors likely to inhibit or increase attendance. Those more likely to attend are older (Hird et al., 1997) and people who perceive their anger as more severe (Awenat, Siddle & Jones, 2002).

The proportion of people referred to clinical psychology departments with specific anger problems has escalated, further increasing waiting list problems (Department of Health, 2003). There is a real challenge to optimise effective treatments within the limited resources both of services and, psychologically, of many angry people.

This paper describes an attempt to address these issues by way of providing a series of anger management classes over a period of two years. It also provides an insight into the process of change involved in developing clinical services in this area.

It is acknowledged that anger may present in a variety of ways, with differing intensity, in different settings and emanating from different causes. These differences may compromise traditional groupwork but be more easily accommodated in a psychoeducational setting that aims to provide basic understanding of emotional processes and general management techniques.

## Aim

The aim was to provide a setting that addressed optimally the needs of the large numbers of people, including a significant minority of women, being referred to the clinical psychology department at Kidderminster with anger problems.

Previous experience in Kidderminster suggested that:

- most people offered individual appointments to address anger problems either fail to attend or opt out of contact at a very early stage;

- 'therapy'-style group interventions are not seen as helpful by the majority of such people; they feel more exposed, leading to heightened anxiety and fear of anger;
- most people referred appear to be discomforted by some aspects of their behaviour and do want help of some kind

Two clinical psychologists (SO'L and JE) decided to set up a psychoeducational anger management class that was overtly teaching rather than therapeutic in style. The programme would be brief, acknowledging ambivalence in attending. We decided on a mixed-gender class, as we felt that, although the majority of referrals were men, the significant number of women referred appeared to share many issues with the men. Many men are angry towards women, but we felt we could manage this dynamic within the class.

### What we planned

Referrers in both primary and secondary care were informed of the new intervention and its aims. People who were subsequently referred were told in advance that the class was to promote understanding and teach techniques and that it was not a therapy group. There was no requirement to participate verbally. The class would be mixed gender and for those over 16.

Referrals were generated from overt referrals to the new class and from routine individual referrals in which anger problems appeared to be the main focus; in the latter case, we contacted referrers to ask if the class might be appropriate.

We decided not to pre-assess people for the class, partly because of the logistical problems in assessing the large numbers of new referrals involved. Both those referred and referrers were sent letters explaining the purpose of the class and giving dates and times of sessions. We additionally asked referrers to contact us if they had any concerns about the person being in a group setting.

The class was held in a comfortable room that could accommodate up to 20 people; a predicted significant DNA rate meant we could safely invite up to 30 participants. The chairs were arranged in a U-shape but angled towards a visual aid, not each other. The visual aid was a flipchart initially,

but we soon developed an OHP package with a structured teaching programme for each session. This helped retain a teaching focus; the two facilitators planned to truncate any personal discussion that moved into deeper areas. The structured content for the three-session programme that evolved was:

- *Session 1:* What is anger? Symptoms. When is anger a problem? Causes. Examples. Ways of dealing with anger.
- *Session 2:* Taking control of anger. Changing thoughts. Solving problems. Communication. Relaxation techniques. Using humour. Changing situations.
- *Session 3:* Dealing with criticism and confrontation. Valid, invalid and 'put-down' criticisms. Handling confrontation. Alternatives to confrontation.

The sessions all lasted for 90 minutes. We began with either two or three weekly sessions with a follow-up at least a month later, but this was modified to a consistent model of three weekly sessions with no follow-up.

A colour handout (an A4 sheet folded into a three-section leaflet) was distributed in session 1, outlining some basic information about anger and its management. People were told that a second, more detailed handout (20 pages of A4) would be distributed in session 2 - a reward for coming back. The latter complemented the overheads.

Session 1 for each class began with a group administration of the State-Trait Anger Expression Inventory-2 (STAXI-2; Spielberger, 1999). The STAXI-2 has three principal scales, measuring state anger, trait anger and anger expression. There are 57 statements relating to anger that are rated on a four-point continuum.

Raw forms were distributed and the 57 statements were read out by one of the psychologists. The initial purpose of this was to collect pre and post measures, and also to orient those attending to some of the areas in which they might be experiencing anger problems.

In Class 4, we introduced a four-item satisfaction questionnaire at the end of session 1.

## What happened

We ran eight classes between October 2000 and March 2003, inviting a total of 179 people; 79 (44 per cent) attended at least one session of their allotted class. Numbers invited to individual classes ranged from 10 to 30, numbers attending one or more sessions ranged from 6 to 15, and percentage attendance in each class (even if for just one session) ranged from 35 per cent to 60 per cent.

There tended to be a drop off in attendance over the course of each class, although attendance was maintained better in classes 5–8 than in classes 1–4. The same two clinical psychologists ran all eight classes.

### *Gender*

Men were more likely than women to be referred and to attend – accounting for 147 (82 per cent) of those invited to the classes and 64 (81 per cent) of those attending. None the less, nearly one in five of the study population were women, and the percentage attendance record (for at least one session) was slightly higher for the 15 women attenders (47 per cent) than the 64 men (44 per cent).

Only two of the eight classes had no women attendees, while two of the classes had four women attending. In some sessions there was only one woman present. There was a male and a female facilitator at all classes.

### *Age*

There was wide variation in age, and age did not appear to predict initial attenders or subsequent drop-outs.

### *Structure*

The pattern of sessions in classes 1–3 was two weekly sessions with a follow-up session, with which we experimented, ranging from four to seven weeks later. In class 4 there were three weekly sessions with a follow-up three weeks later. In classes 5–8 there were three weekly sessions with no follow-up.

### *Anger measure*

The STAXI-2 was administered as a pre and post measure in class 1, but the post measure was not continued with because of the high attrition rates in the follow-up session in classes 2–4.

The average score for State Anger over all eight classes was 65 (range 30–99), the Trait average was 90 (range 35–99) and the Anger Expression index average was 91 (range 40–99). The Trait and Anger Expression scores were particularly high, indicating that those referred had major problems in handling anger. In some classes, most of the participants had served prison sentences for violent offences.

The lower State-Anger score might indicate anger being displaced by anxiety in a novel situation – or relief at a core issue being addressed.

### *Satisfaction*

The satisfaction questionnaire at the end of session 1 (classes 4–8) showed that 91 per cent of responders felt that the class showed a better way to handle their problems, 84 per cent felt that the issues discussed were relevant to them, and 84 per cent felt more hopeful that they would be able to tackle their problems.

The fourth question created an even split between those who would have liked more individual time to discuss their own problems and those who would not. A number of people resumed pre-existing individual contact with other clinicians after their class, and some newcomers asked for (and were offered) subsequent individual sessions.

## Discussion

The classes appeared to have met at least some of the needs of those who attended. The satisfaction questionnaire at the end of the first session was positive, and, although there was no formal assessment of satisfaction at the end of each final session, there was clear and widely expressed gratitude expressed by most members at the ending of each class.

Within the sessions, many class members talked positively about presentation content and style, and cited experiments with some of the techniques taught. Such feedback has become more enthusiastic as the classes have evolved, suggesting that the psychologists may be becoming more skilled at both presentation and management of the classes.

The first class had started out inauspiciously with one young class member interrupting our preamble to announce ‘I just want to say that

I've been in a group just like this before, and I can tell you all it is a total waste of time.' Such comments - there were very few - were reflected on and used to illustrate teaching.

Participants would sometimes challenge one another. This was generally respectful: over the eight classes, we had only one problematic incident. A young man defiantly rejected any attempt to engage with problems he had cited and got into a mutually retaliatory argument in the final session with a older man bent on giving everyone his unbudging advice. The young man stormed out of the class, and rejected overtures to return after we followed him out.

Fears that managing a group of angry people without pre-assessment might feel unsafe proved ill-founded. Most of the participants wanted to contribute verbally and were easy to engage with; those who appeared to seek a more peripheral role were allowed to do so.

The participation of women was interesting. Having only one female participant in particular sessions was unsatisfactory, but some of these women made a significant verbal contribution and women did not appear to be proportionately more inhibited in this regard than men. In class 8, the four women members very much took the lead. It felt helpful having a male and female presenter. Of those women who did attend, none appeared (to either facilitator) to be subject to any obvious gender-based hostility from male participants.

We plan to continue with three classes per year, and to introduce other psychologists. Management of such classes requires, we think, skills in balancing sensitivity and robustness that would present significant problems for inexperienced clinicians.

We are also considering extending the 'class' system to other areas of service to offer people choices between therapy and psychoeducational approaches.

## References

Anderson-Malico, R. (1994). Anger management using cognitive group therapy. *Persepectives in Psychiatric Care*, 30, 17-20.

Awenat, F., Siddle, R. & Jones, F. (2002). The anger characteristics of people who attend for treatment compared with non-attenders. *Clinical Psychology*, 13, 19-22.

Cornell, D. G., Peterson, C. S. & Richards, H. (1999). Anger as a predictor of aggression in incarcerated adolescents. *Journal of Consulting and Clinical Psychology*, 67, 108-115.

Deffenbacher, J. L., Oetting, E. R., Lynch, R. S. & Morris, C. D. (1996). The expression of anger and its consequences. *Behaviour Research and Therapy*, 34, 575-590.

DeMoja, C. A. & Speilberger, C. D. (1997). Anger and drug addiction. *Psychological Reports*, 81, 152-154.

Department of Health. (2003). *Hospital Waiting Times 2002-3*. London: Department of Health.

DiGiuseppe, R. & Tafarate, R. C. (2003). Anger treatment for adults: A meta-analytic view. *Clinical Psychology: Science and Practice*, 10, 1.

Greene, A., Coles, C. & Johnson, E. (1994). Psychopathology and anger in interpersonal violence offenders. *Journal of Clinical Psychology*, 50, 906-912.

Hird, J., Williams, P. J. & Markham, D. M. H. (1997). Survey of attendance at a community-based anger control group treatment programme with reference to source of referral, age of person and external motivating features. *Journal of Mental Health*, 6, 47-54.

Jacobson, N. S., Gottman, J. M., Waltz, J., Rushe, R., Babcock, J. & Holtzworth-Munroe, A. (1994). Affect, verbal content, and psychophysiology in the arguments of couples with a violent husband. *Journal of Consulting and Clinical Psychology*, 62, 982-988.

Mayne, T. J. & Ambrose, T. K. (1999). Research review on anger in psychotherapy. *Psychotherapy in Practice*, 55, 353-363.

Munro, F. & Macpherson, G. (2001). Anger management fast-track: A waiting list initiative utilising a large group format. *Clinical Psychology Forum*, 147, 30-34.

Speilberger, C. D. (1999). *State-Trait Anger Expression Inventory-2*. Lutz, FL: Psychological Assessment Resources.

Vailliant, P. M. & Raven, L. M. (1994). Management of anger and its effects on incarcerated assaultive and non-assaultive offenders. *Psychological Reports*, 75, 275-278.

White, J. (2000). *Treating Anxiety and Stress: A group psycho-educational approach using brief CBT*. Chichester: Wiley.

Whiteman, M., Fanshel, D. & Grundy, J. (1987). Cognitive-behavioral interventions aimed at anger of parents at risk of child abuse. *Social Work*, 32, 469-474.

## Address

Simon O'Loughlin, Department of Clinical Psychology, Kidderminster General Hospital, Bewdley Road, Kidderminster, Worcestershire DY11 6RJ

# To attend or not to attend: 'seasonal' and school term influenced variation in non-attendance rates at a CAMHS outpatient clinic

Lynne Taylor and Rachael Smith, Grampian Primary Care NHS Trust

*This three-year audit examines missed appointment rates of new and current cases at an outpatient clinic for young people (13-18 years old) with mental health difficulties. Preliminary data suggest that time of year influences attendance rates. Implications for CAMHS service delivery and planning are discussed.*

The Young People's Department (YPD) at Royal Cornhill Hospital provides an outpatient service to young people aged between 13 and 18 with general mental health difficulties. As occurs within the majority of NHS outpatient services, a number of people miss or cancel their appointments. This results in a multi-dimensional cost to the health service, including wasted professional time and resources, increased administration time, a potential cost to the client in terms of loss of a beneficial service and a loss to other people requiring services (Humphreys et al., 2000). Furthermore, non-attendance has the potential to generate or increase waiting lists if these already exist. Consequently identification of factors promoting attendance and non-attendance is potentially useful.

Grunebaum et al. (1998) studied predictors of missed appointments for psychiatric consultations in an adult clinic. They found that those who had minimal distress, significant resistance to seeing a psychiatrist, or had to wait longest for an appointment were the most likely to miss appointments. Other studies have found that those who missed appointments tended to be younger and have fewer psychological difficulties (Winterbottom et al. 1998). Sparr et al. (1993) found that the most

commonly reported reason for missing appointments was patient error such as forgetting or mistaking the date.

There has been relatively little investigation of this subject in adolescent populations, which is surprising given the high number of missed appointments and significant under treatment of mental health problems in this age group (Feehan et al. 1993). As indicated by Pelkonen (2000), 45-77 per cent of child and adolescents referred to mental health services do not commence treatment, or terminate it prematurely (Armbruster & Fallon, 1994; Trautman et al., 1993). Wierzbicki and Pekarik (1993) also indicated that little research has been done in this area and different variables are related to dropout in adults and young people and consequently future research should analyse these populations separately.

Pelkonen (2000) examined background factors, psychopathology, and psychosocial impairment among 197 adolescents (age 12-22 years) from Finland who complied or dropped out of outpatient mental health treatment. The main factors identified for missed appointments were low parental socio-economic status, evidence of substance abuse, not having psychotropic medication and not having a mood disorder. Staudt (2003) also identified level of engagement in intervention as a factor for dropping out of CAMHS services. Additional factors such as an unsupportive family ethos have also been recognised (Vander Stoep et al., 1991).

The multidisciplinary team at the Young People's Department consists of psychiatry, clinical psychology, nursing, occupational therapy and social work. Our service encompasses tier levels 2-3 (Health Advisory Service) receiving referrals from

GPs, community or hospital child health, psychiatry and clinical psychology colleagues, educational psychology and social work. (The department does not provide a service to young people with learning disabilities.) The team considers referrals and where appropriate it is decided which member of the team would be most suited to offer the young person an appointment. The young people are sent an appointment time by letter, generally within a 6–8 week period, depending on both the referrer and the team's deemed urgency of the difficulty. The majority of appointments are offered at the adolescent outpatient department located within Royal Cornhill Hospital, Aberdeen, but also at various different clinics located in the periphery or home visits.

The YPD team has always suspected that fewer young people attend our service during holiday periods, and speculated that getting time off school or work during non-holiday periods is an incentive for this age group to come to appointments, whilst giving up their holidays is not. No known published studies have investigated whether time of year influences attendance at adolescent outpatient mental health clinics. To examine this, a retrospective audit of attendance rates of new and current cases over each month of a three-year period was conducted. The aim

was that information drawn from this audit could be used to inform practice, guide further research, and assist in the shaping of service delivery and planning in CAMHS.

## Method

The number of young people attending, cancelling or otherwise missing appointments with all clinical staff (14 in total) is collated monthly. Data for missed appointments for a three-year period (2000–2) were analysed separately for initial assessment (new cases) and young people who have already been seen (current cases). A non-attendance rate (including cancellations and failure to attend without notice) was obtained and converted to give a percentage non-attendance rate for the department each month. Within this initial audit, we did not separate cancelled versus uneventuated appointments or identify any further specific information on patient characteristics as this was not possible to determine from the retrospective nature of the data.

## Results

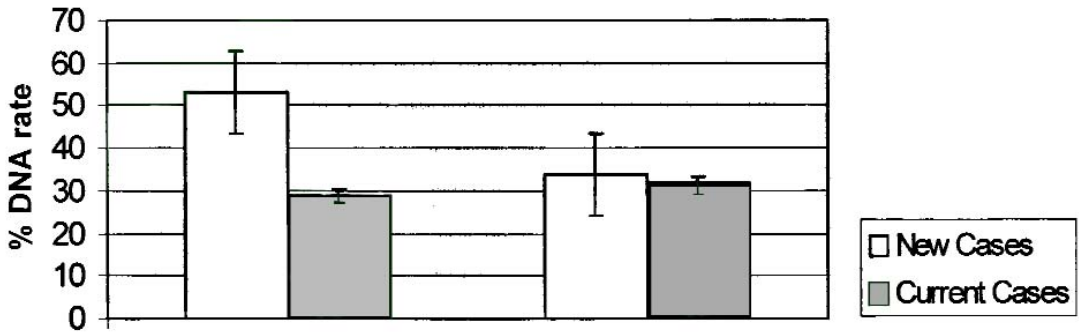
Due to the nature of the data the results are mainly descriptive. Table 1 shows that there appears to be a higher non-attendance rate in holiday periods particularly during Summer (July), but also around Easter (April), school exam time (May), October

**Table 1.** New cases: % missed appointments by month over three-year period

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2000	38.5	24.4	33.8	36.8	44.1	41.3	58.1	37.0	28.9	39.7	37.2	42.9
2001	34.4	30.0	22.7	34.8	30.8	35.2	50.0	45.1	25.0	32.7	30.2	36.2
2002	20.9	34.0	28.9	36.7	44.9	22.7	51.3	41.1	33.8	30.9	33.3	37.3

**Table 2.** Current cases: % missed appointments by month over three-year period

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2000	26.0	28.5	36.2	36.1	34.0	31.8	33.9	31.9	36.6	32.1	37.4	33.3
2001	26.8	36.4	28.4	29.9	28.0	27.6	36.0	28.3	31.0	26.6	32.3	24.2
2002	23.7	29.1	30.7	31.5	32.9	27.8	31.8	28.9	28.2	29.4	24.0	24.5



**Figure 1.** Holiday versus non-holiday month (error bars represent standard error of the mean)

break and Christmas (December). This trend is for new cases only, with Table 2 demonstrating that current cases demonstrate a fairly steady non-attendance rate throughout the year. Comparing the months of July (a holiday month for school attendees) and September (a non-holiday month), the mean total percentage of missed appointments for new cases over three years was 53.2 per cent in July versus 29.2 per cent in September. The mean total percentage of missed appointments for current cases over three years was 33.9 per cent in July versus 31.9 per cent in September. Figure 1 displays error bars representing the standard error of the mean which demonstrates that missed appointment rates do increase in holiday periods, especially during July; however, this is only apparent for new cases.

## Discussion

The main finding from this study was that there appeared to be a higher percentage of missed first appointments during the school exams and holiday periods, particularly summer. This did not appear to be the case for revisit appointments. There appears to be a similar trend for a higher percentage of missed or cancelled appointments during the Easter and Christmas periods in new cases. However, as the data were recorded monthly by the department, it was not possible to analyse this trend in more detail as these holiday periods differ each year.

It was not hypothesised that this trend would occur only with the new cases and not for young people who had revisit appointments. There are a number of possible explanations for this find-

ing. New cases are sent a time suitable for the health professional; appointment times for repeat visits are generally arranged at a time suitable for both professional and young person, which increases the likelihood of attendance. Furthermore, parents are generally aware of the time of the revisit appointment, and may persuade the young person to reattend, which may not be the case if an initial appointment has been addressed to the adolescent only. It is also noteworthy that current clients have generally agreed to come back and lower rates of missed appointments in this population may be related to engagement with the health care professional and therapy already offered. There is an ethos within the department to stress to young people the need to maintain engagement with the department and to view their appointments as a priority. It may also be the case that those who were already being seen were the ones who were more likely to attend, as they attended for their first appointment and are therefore less likely to miss subsequent appointments.

There are other possible explanations for a higher non-attendance rate in holiday periods. It is proposed that some adolescents do not prioritise their appointment over time with their peers during the summer months. Additionally, anecdotal evidence suggests that getting time off school is an incentive to come during non-holiday periods. Clinical experience suggests that many young people's difficulties are significantly better during holidays, for reasons such as reduced peer and educational pressures, and some young people may feel less need to attend.

The results of this preliminary audit have implications for service delivery, planning and training within CAMHS. Given the high cost of missed appointments to the health service, some consideration must be given to this issue. During peak times of new cases not attending, an opt-in or reminder system could be implemented, where not already in place. Other strategies to minimise this potentially expensive trend would be to utilise peak non-attendance periods by, where possible, scheduling non-clinical activities and commitments such as teaching, training, consultation or research. Having a general awareness that more non-clinical time may be available at peak non-attendance times is also beneficial and may in fact temporarily alleviate staff demands regarding non-direct clinical activity.

It is recognised that data may be compounded by variations in clinical populations, stigma of seeing the health professional involved, and location of appointments as well as more general factors such as parental issues, socio-economic status or sex. However, the trend has remained fairly robust over the three years and therefore appears to be an area worthy of further investigation.

### Acknowledgements

Thanks to Dr Janette Eagles (Associate Specialist in Psychiatry, Young People's Department, Royal

Cornhill Hospital, Aberdeen) for collecting and collating audit data over the three year period.

### References

- Armbruster, P. & Fallon, T. (1994). Clinical, socio-demographic and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry*, 64, 577-585.
- Feehan, M., McGee, R. & Williams, S.M. (1993). Mental health disorders from age 15 to 18 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 1127-1134.
- Grunebaum, M., Luber, P., Callahan, M. et al. (1998). Predictors of missed appointments for psychiatric consultations in a primary care clinic. *Year Book of Psychiatry and Applied Mental Health*, 7, 231-232.
- Humphreys, L., Hunter, A.G., Zimak, A., O'Brien, A., Korneluk, Y. & Cappelli, M. (2000). Why patients do not attend for their appointments at a genetics clinic. *Journal of Medical Genetics*, 37, 810-815.
- Pelkonen, M. (2000). Factors associated with early drop-out from adolescent psychiatric outpatient treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 3, 329-336.
- Sparr, L. F., Moffitt, M. C. & Ward, M. F. (1993). Missed psychiatric appointments: Who returns and who stays away? *American Journal of Psychiatry*, 150, 801-805.
- Staudt, M. (2003). Helping children access and use services: A review. *Journal of Child and Family Studies*, 12, 49-60.
- Trautman, P. D., Stewart, N. & Morishima, A. (1993). Are adolescent suicide attempters noncompliant with outpatient care? *Journal of the American Academy of Child Adolescent Psychiatry*, 32, 89-94.
- Vander Stoep, A., Bohn, P. & Melville, E. (1991). A model for predicting discharge against medical advice from adolescent residential treatment. *Hospital and Community Psychiatry*, 42, 725-728.
- Winterbottom, L. M., Joos, S. K. & Hickman, D. H. (1998). Characteristics of patients who miss revisit appointments in primary care clinic. *Journal of General Internal Medicine* 13, 68.
- Wierzbicki, M. & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology Research and Practice*, 24, 190-195.

### Address

Young People's Department, Lower Garden Villa, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH;  
Lynne.Taylor@gpct.Grampian.scot.nhs.uk

## Child Forensic Special Interest Group

Next meeting

**Wednesday 21 January 2004**

(11 a.m. – 4 p.m.)

British Psychological Society London Office,  
33 John Street, London WC1

This is a newly established group for all clinical psychologists working in the field of forensic child and adolescent mental health.

For further information or to confirm your place at this day please contact Lesley French:

Tel: 020 7530 6468/6422 or e-mail:

[l.french@nhs.net](mailto:l.french@nhs.net)

# The Outlook summer group: a social skills workshop for children with a different appearance who are transferring to secondary school

Lynn Maddern and Tina Owen, North Bristol NHS Trust

*This paper describes a summer workshop run by Outlook at North Bristol NHS Trust. The workshop was developed for children whose appearance is affected either by a congenital condition or trauma. The children attend prior to transferring to secondary school. Cognitive Behaviour Therapy (CBT) underpins problem-solving activities to tackle teasing, using narrative, metaphor, role-play and games. Parents attend a parallel group and both groups meet for a reunion following transfer to secondary school. Interest has been expressed by other centres, so a detailed description of the programme is given to enable others to run similar groups.*

Two in every 1000 children have a ‘scar, blemish or deformity that limits daily activity’ (OPCS, 1989). Many more have less noticeable disfigurements. Even minor visible differences can be a source of distress and concern for children at all ages (Landsdown, 1990). Adolescents with a cleft lip and palate, burns or other disfiguring conditions are vulnerable to bullying at school and consequent emotional distress. In coping with their visible difference, the child’s confidence and social skills are more significant than the type or severity of their disfigurement (Robinson et al., 1996).

School transition is a huge adjustment for all children. Changing friendship networks and new educational and social demands conspire together to make this a challenging time. Children who have experienced separation from parents, hospitalisation or traumatic injury during childhood may find such traumas exacerbate transition dif-

ficulties (Durkin, 2000).

Psychological care for children with a visible difference has been patchy or non-existent in the UK. Most of the work to support families is condition-specific and takes place within the voluntary sector. Previous interventions for children who look different, by Outlook and others (see Kish & Lansdown, 2000, for a discussion), have been aimed at individual children. Working with children in a group is less common. The prime exemplar in this area is the burns camp. The majority of children benefit from these camps, for example, in the development of friendships and confidence (Doctor, 1992; Cassidy, 1996). Social skills groups for children foster co-operative learning and social development (Ogilvy, 1994).

Outlook was established seven years ago with joint funding from the NHS and Changing Faces (a national voluntary organisation which provides psycho-social support to people with visible difference) and is now NHS funded. Children are referred to Outlook by a range of health professionals, principally plastic surgeons and dermatologists, for difficulties in coping with their own feelings as well as other people’s reactions to their appearance. The child service provides a range of services to children and their parents including information and advice, individual assessment and therapeutic interventions with the children, support and counselling to parents, and the summer group – a specialist group session for children, with a parallel session for parents. Any child who has been referred is offered the summer group when they reach Year 6 at primary school.

The children seen at Outlook are typically more introverted than their peers, scoring at the top end of the normal range for psychosomatic symptoms

and anxiety on the Child Behaviour Checklist (Achenbach, 1991). They often face daily taunts, teasing, name-calling and stares. Like all children, they have a limited range of strategies for dealing with these situations. However, on the whole, they are not children with major family complications or social issues, unlike the population of children seen by child and adolescent mental health services, for example. In general, therefore, they are readily able to relate to and use the ideas discussed at Outlook, and often make considerable progress in a very short time. Outlook's summer group enhances the children's toolkit of available options when faced with a social challenge, and provides on-the-spot evidence of their ability to meet new peers and make friends.

All children in Year 6 who have had contact with Outlook, are offered the summer group. The service covers the whole of the South West, which precludes some families from attending for regular individual support, but a single workshop is more realistic.

Increasingly, we have been involving parents in the process, hence the decision to run a parallel parents group, where parents share their stories. At a practical level, parents hear about the strategies being learned by the children and are therefore better able to support their child at home.

The structure and format of the group has evolved, resulting in the arrangement discussed here. The feedback from the children and parents, together with our observations of what works well, has guided our decisions about the format and timing of the sessions.

There has been considerable interest from others in the model we use with the materials and ideas being taken up and used by Changing Faces. This link is an encouraging example of co-operation and support between voluntary and statutory services.

## The Group

### *Group specification*

- The children:
  - 10-11 years of age (year 6);
  - Six to eight children per group;
  - children with a range of appearance-related conditions including cleft lip and

palate, birth marks, burns and traumatic injury;

- referred by health professionals, primarily GPs and consultants.

### ■ Staffing:

- clinical psychologist, co-therapist (possibly an assistant psychologist, trainee or counsellor) and art teacher with the children;
- outreach specialist (trained in counselling and group work) with the parents.

### ■ Timing:

- half day in May or June;
- follow-up session in October.

### *Aims and objectives*

- To provide supportive environments separately, for children and parents to share and discuss experiences.
- To enable children to practise strategies for integrating with a new social group.

### *The theoretical base*

The group is modelled on an established social skills group programme with primary-aged children using Cognitive Behaviour Therapy (CBT) (Maddern et.al., in press). Children are encouraged to explore their difficult experiences, which often take place in the school playground, and reflect on their thoughts and feelings when confronted by teasing or name-calling. The children are taught problem-solving techniques to expand their repertoire of responses. Role-play provides vital experience in connecting with their feelings when acting out these solutions (Carbonell & Parelano-Barehmi, 1999). 'Automatic negative thoughts' and similar jargon is kept at bay, but children are quite capable of identifying thoughts that often 'pop into their mind'.

Non-competitive games help both to relax anxious participants at the outset and to keep the energy going through the session. An art project has been a core component, allowing the children to produce a piece of artwork together. This is

later ceremonially hung when the children return for their follow-up session.

### *Protocol for the Children's Group*

The structure of the children's group is as follows.

- *Circle time.* Welcome and introductions.
- *Game – fruit salad.* A warm-up game to get the energy flowing. The children sit in a circle and swap chairs as their fruit is called. Fruit salad has everyone on their feet swapping chairs.
- *Group discussion.*
  - *What are you looking forward to about Secondary School?* Common themes are: new subjects (for example, drama, IT and languages) new friends and new sporting opportunities.
  - *What are you worried about?* Common themes are: homework, detentions, getting lost and teasing.
- *Game: Wink murder.* The popular game involving detectives, murderers, winking and noisy deaths, excellent for eye contact.
- *Art session (first part).* Past artwork has included several silk batiks.
- *Juice and biscuits.*
- *Game: crossing a crocodile infested river.* The children work as a team getting from one side of the room to the other, using four chairs, without touching the floor, in case they are eaten by a crocodile.
- *Dolphins, fish and sharks (making friends).* Using the metaphor of the underwater playground, in which small fishes (passive), schools of dolphins (assertive) and sharks (aggressive) play the familiar playground characters, the child is encouraged to find ways to be 'more like a dolphin': sociable, friendly and supportive to their friends. The children role-play making friends; for example, making an approach, listening to a conversation, joining in, asking questions and joining in a game.

- *Dealing with teasing (seeing off the sharks).* Fogging = assertive = being 'more like a dolphin'. Children learn to counteract name-calling by using a string of blocking words: 'so ... whatever ... boring ... absolutely ... yeah, yeah, yeah'. This is role played with puppets: each child experiences the victim and bully perspective and the difference between a passive and an assertive response.

Other solutions explored include using humour and knowing when and how to ignore provocation and to ask adults for help.

- *Complete the artwork.*
- *Closing circle.*
- *Displaying the artwork.* Children show off their artwork to parents, a reunion reminder is given for the follow-up session and a picnic lunch is eaten together.
- *Ends.* This format can be varied according to the skills and interests of the therapists. It is advisable to have one key worker who is experienced in working with children, preferably with groups.

### *The parents' group*

Initially parents introduce themselves and describe their child. It is left to them how much they share about their child's condition. This is followed by an open discussion about the children moving on to secondary school. The parents share their experience about what has been helpful in overcoming difficulties in the past. Normalising the experience of having a child changing school is important, together with practical advice about who to contact at the school if there are any concerns. Parents are given information and resources for themselves, their child and the school.

The parents' group has become more important and longer year by year and now feels as important and significant as the children's group. However, without doubt it is the children's group that brings the families to Outlook for the day. Parents on their own would be far less likely to attend a group, so this situation capitalises on their presence to positive effect.

### *The follow up group*

Both the children and parents meet for a follow-up session in the October half-term holiday, after they have made the transition to secondary school. The children review the joys and anxieties of their secondary school experience and are eager to hear each other's stories. Any reports of teasing are listened to and the group share ideas about possible solutions. The session ends with the artwork being ceremonially hung on the wall. For most children this will be their last formal contact with Outlook, but families are assured that they can return for further advice as necessary in the future.

### **Evaluation**

Written and verbal feedback was obtained from each children's and parents' group, and the suggestions and advice were incorporated into subsequent groups using an iterative process with six cycles of group intervention and reflection so far, informing the design of the programme. When asked what was best about the group, children's comments included:

Making the batik, playing wink murder and the fruit salad game, but best of all was the help with the worries and teasing.

It was very good to see that you are not just worrying alone.

Parents' comments included:

I don't feel so lonely and cut off now.

Being able to talk and listen with other parents whose children are going through the same thing.

### **Discussion**

The summer group provides a relatively easy and inexpensive intervention, which is seen as helpful by children and parents. It may be an acceptable option for those who find the idea of individual psychology sessions a little uncomfortable. The group's success is in part due to the timing of the programme, but also to its normalising culture.

School transfer is seen as a key stage for all children. However, children with a different appear-

ance are aware that they may be subjected to questions, staring and teasing, and that they, unlike others, cannot fade easily into the background (Walters, 1997). The summer group is designed to boost the child's resilience and confidence and provides a forum to share experiences. For the parents, a parallel opportunity is available to tackle feelings of anxiety and isolation.

The summer group has become something of a hallmark of the service and is identified by families and the wider clinical team as a positive and human experience amidst what is often lengthy medical care.

Outlook has had many requests for its programme and we hope that by publishing it here we will enable other units to take our format and adapt and develop it to the needs of other children and families.

### **References**

- Achenbach, T. M. (1991). *Manual for the Child Behaviour Checklist/4-18 and 1991 Profile*. Burlington, VT: University of Vermont Department of Psychiatry.
- Carbonell, D.-M. & Pateleno-Barehmi, C. (1999). Psychodrama groups for girls coping with trauma. *International Journal of Group Psychotherapy*, 49, 285-306.
- Cassidy, J. (1996). Adventure holiday takes off the heat. *Nursing Times*, 92, 16.
- Doctor, M. E. (1992). Burns camps and community aspects of burn care. *Journal of Burn Care and Rehabilitation*, 13, 68-76.
- Durkin, C. (2000). Transition: the child's perspective. *Educational and Child Psychology*, 17, 64-75.
- Kish, V. & Lansdown, R. (2000). Meeting the psychosocial impact of facial disfigurement: developing a clinical service for children and families. *Clinical Child Psychology and Psychiatry*, 5, 497-512.
- Lansdown, R. (1990). Psychological problems of patients with cleft lip and palate: A discussion paper. *Journal of the Royal Society of Medicine*, 83, 448-450.
- Maddern, L., Franey, J., McLaughlin, V. & Cox, S. (in press). An evaluation of the impact of an inter-agency intervention programme to promote social skills in primary school children. *Educational Psychology in Practice*.
- Office of Population Censuses and Surveys (1989). *Report 3: The prevalence of disability among children*. London: HMSO.

Ogilvy, C. M. (1994). Social skills training with children and adolescents: a review of the evidence on effectiveness. *Educational Psychology*, 14, 73–83.

Robinson, E., Rumsey, N. & Partridge, J. (1996). An evaluation of the impact of social interaction skills training for facially disfigured people. *British Journal of Plastic Surgery*, 49, 281–289.

Walters, E. (1997). Problems faced by children and

families living with visible difference. In R. Landsdown, N. Rumsey, E. Bradbury, T. Carr, & J. Partridge (Eds.) *Visibly Different Coping with Disfigurement*. Oxford: Butterworth-Heinemann.

#### Address

East Bristol CAMHS, North Bristol NHS Trust, Downend Clinic, Buckingham Gardens, Downend, Bristol BS16 5TW

# From Galton to the Human Genome Project

## A critical appraisal of genetic theories in psychology and psychiatry

The TechnoCentre, Coventry University  
28 January 2004

### *Speakers*

**Prof. Richard Bentall**, Manchester University;

**Prof. Mary Boyle**, University of East London

**Dr Jay Joseph** (author of *The Gene Illusion*)

### *Topics include*

- Twin research in psychology and psychiatry: pitfalls and fallacies
- The genetic basis of psychiatric disorders: axiom or hypothesis
- How can we raise public and media consciousness of critical issues in genetic and behavioural research?

### *Conference booking forms and further details*

Heather Allan, PCCS Books, Llangarron, Ross-on-Wye, Herefordshire  
HR9 6PT; Tel: 01989 770707; Fax: 01989 770700;  
e-mail: [enquiries@pccsbks.globalnet.co.uk](mailto:enquiries@pccsbks.globalnet.co.uk)

# A sign of our times: clinical psychologists' awareness, concerns and interest in supervising a deaf trainee

Alexandra Dent and Rachel Atherton, Leicestershire & Rutland NHS Trust

*The first deaf clinical psychology trainee was accepted on to a London training course in September 2000. This study evaluates clinical psychologists' experience of deaf culture as well as their interests and opinions about supervising a deaf trainee.*

Clinical Psychology services need to offer diverse and culturally appropriate services. Kazarian and Evans (1998) suggested that this could be achieved by increasing the number of people from minority groups into clinical psychology training and by addressing cultural issues and awareness during training. In 1990, the first intake on a doctorate programme for clinical psychology was available to deaf people in the USA. By 1996, Pollard reported that the course had 29 students of whom a third were from deaf or hard of hearing.

The United Kingdom trails considerably behind America. The number of deaf people with relevant degrees and experience in the UK is increasing (Cromwell & Atherton, 2000), and the first deaf person was accepted on a clinical psychology course in 2000 (Cromwell, 2001).

The aim of this project was to evaluate clinical psychology supervisors' concerns and interests in supervising a deaf trainee in the Trent Region. Although there are currently three specialist mental health services for deaf people in the United Kingdom, these services may not be able to provide all the core placements of the training course required by the British Psychological Society's accreditation process. In addition, it may not be the wish of the deaf trainee to work

exclusively in such settings. Therefore it is important to identify possible clinical psychology supervisors in various regions throughout the country who would be interested in supervising a deaf trainee.

## Method

A questionnaire survey with postal return formed the design of this study. A list was obtained of everyone in the Trent Region who was currently a clinical psychology supervisor or had been one over the past seven years.

The questionnaire, designed by the first author, consisted of a combination of specific questions, rating scales and open-ended questions. There were three main sections, seeking general information about supervisor's place of work, supervisor's experience of deaf culture and specific areas that may or may not cause concern to supervisors if offering a placement to a deaf trainee. Finally, two open questions were provided to allow supervisors to discuss perceived difficulties in offering a placement, as well as ways in which these could be overcome.

## Results

Of the 220 questionnaires sent out to supervisors, 120 were returned (response rate of 55 per cent). Three were returned blank because the recipients were no longer supervising trainees. Of the remaining 117, not all items were answered. The values given below represent the results from those questions answered.

Supervisors generally had been qualified for some time (mean 13.4 years, SD 7.8) and supervised at least one trainee a year. They worked in

a variety of placements that were representative of the diversity of placements offered on UK Clinical Psychology training courses.

### *Supervisors experience of deaf culture*

There were 36 supervisors (31 per cent) trained in deaf awareness, mostly through personal interest, and this knowledge had been used in their work. Few supervisors had any formal training in BSL or Sign Supported English and only 14 had learnt Makaton (a unique programme used to teach language, communication and literacy skills). Despite the lack of knowledge about the availability of training courses in the workplace, many ( $n=65$ , 59 per cent) reported an interest in attending a course.

There was a slightly better awareness of deafness in the workplace with respect to clients. Just over half of supervisors ( $n=62$ , 53 per cent) knew that deaf clients had been referred to their service and nearly half of these supervisors ( $n=27$ , 43 per cent) had worked in some way with at least one client. Although only a quarter of supervisors ( $n=31$ , 26.5 per cent) knew of another clinical psychologist working with deaf clients, more ( $n=44$ , 38 per cent) were aware of other professionals in their service working with deaf clients.

Nearly a quarter of supervisors ( $n=27$ , 23 per cent) knew of a deaf healthcare professional, the majority of whom worked in social services. Just over a third of supervisors had worked professionally with a deaf person, with work varying from assessments, working with an interpreter, multidisciplinary work and consultation.

### *Supervisors' opinions on offering a placement to a deaf trainee*

Supervisors were asked to rate on a Likert scale their opinions about offering a placement to a deaf trainee who used BSL as their first language. Only 17 (15 per cent) expressed a great deal of interest in offering a placement to a deaf trainee. A third ( $n=35$ , 30 per cent) had minimal awareness of deaf issues and most ( $n=65$ , 59 per cent) rated their ability to communicate with a deaf trainee as low. The majority ( $n=65$ , 59 per cent) did not feel able to communicate very well with a deaf trainee. There were similar results across

the scale regarding concern for extra time in supervision as well as concern that the trainee may not understand the hearing culture.

One concern was the extent to which some supervisors ( $n=33$ , 30 per cent) felt that a deaf trainee would be unable to fulfil all aspects of the clinical psychologists role. Many ( $n=47$ , 44 per cent) were also concerned about the trainee's ability to communicate with clients. There were 36 supervisors (32 per cent) who expressed concern about the effect of the presence of an interpreter on the therapeutic relationship with the client. In contrast, only eight supervisors (7 per cent) expressed concern about the trainee communicating within multidisciplinary teams.

Finally, most supervisors ( $n=79$ , 75 per cent) rated their services as poorly resourced in terms of technical aids for deaf people, and there was a variable response in relation to the amount of support that supervisors thought their service would offer.

Supervisors felt that funding for training should be jointly shared between professional bodies including the training course, NHS and the local Trust.

Earlier responses were compared with the four core placement settings that supervisors worked within (adult, older adult, child or learning disabilities). Supervisors in learning disability settings were more aware of deaf issues than those in other core placements ( $H=10.7$ ,  $p=0.01$ ), were less concerned about the trainee understanding the hearing culture ( $H=8.03$ ,  $p=0.05$ ) and felt they had better resourced departments ( $H=8.02$ ,  $p=0.05$ ).

When supervisors offering core placements were compared with those who did not, no significant differences were found. In contrast, supervisors offering specialist placements were more aware of deaf issues ( $U=765.5$ ,  $p=0.05$ ) than those not offering specialist placements.

Supervisors were also asked to list up to three perceived difficulties that deaf trainees may experience on placement, as well as ways in which these difficulties could be overcome. Six themes were identified for difficulties, illustrated in Table 1, with the main theme being communication, both within teams and between individuals. The other main theme centred on trainees, especially their ability to cope and their limitations

**Table 1.** Supervisors' responses to the most difficult aspects of the placement for a deaf trainee

Theme	n (%)	Examples
Communication	86 (38)	Problems both within teams and individuals
Trainee difficulties	57 (25)	Inability to cope with difficult clients, psychometrics, group work, isolation, relationships and safety
Organisational issues	29 (13)	Environmental difficulties, lack of resources and support
Staff and clients	27 (12)	Extra time needed, lack of understanding, decreased skills, attitudes and prejudices
Supervisors' personal concerns	15 (6)	Extra time, lack of privacy, knowledge and competence
Use of an interpreter	14 (6)	Consistency, confidence, concentration, disruption, availability and ability to cope

**Table 2.** Supervisors' responses to the ways in which problems could be overcome

Theme	n (%)	Examples
Training	52 (29)	Early training in deaf awareness, cultural changes
Interpreters	33 (18)	Use of, stability, consistency, increasing interpreters' awareness of mental health issues, guidelines, funding
Technical aids	19 (11)	Use of e-mail, special telephones and faxes
Resourcing	18 (10)	Including both clinically and from the training course
Practical work	17 (9)	Written communication, joint casework, live supervision, information, videos, workshops, different approaches (i.e. non-verbal)
Planning	15 (8)	Pre-placement, induction, liaison with other professionals, specialist services and placements
Additional time	14 (8)	With clients and in supervision
Involving the trainee	9 (5)	Trainees to be clear and directive about their needs, trainee learning by exposure and experience
Service set-up	4 (2)	Giving clients choice and information, explanation and reassurance

with certain aspects of the job, for example group work and psychometrics.

Methods for overcoming difficulties were wide ranging and are illustrated in Table 2, with the

most popular response suggesting training for clinical psychologists. Another popular theme was use of interpreters who have mental health training.

## Discussion

Overall, the majority of respondents reported a lack of understanding of deaf awareness as well as limited resources from services. The main concerns were the ability of a deaf trainee to communicate with clients and possible limitations in the clinical psychology role.

Supervisors offering learning disability placements were more aware of deaf issues, had better departmental resources and were less concerned about the hearing culture. This may be due to the fact that other forms of communication are more common (e.g. Makaton) within the client group that they work with. Furthermore, people with learning disabilities often have some form of physical impairment and services may be set up to accommodate these. Specialist areas may attract people with an interest in developing skills beyond the workplace or may have exposure to specialist skills in the workplace.

## Recommendations

Although a deaf trainee's needs and requirements will vary from one individual to another, based on the results obtained, some recommendations are presented and are divided into two stages. This is not intended to be an exhaustive list but rather to promote discussion. The first stage should ideally commence before a deaf person begins training and the second is for post recruitment.

Recommendations for the first stage could be the joint responsibility of the training course and NHS. These include:

- identifying needs and levels of support anticipated by setting up a forum with deaf assistant psychologists and other representatives from different aspects of the course (i.e. academics, clinicians, researchers);
- determining funding responsibilities, to include use of interpreters with mental health service experience when required;
- identifying people interested in working with a deaf trainee in the area and improve links with other specialist services and professionals;

- investigating the use of signing policies in situations where a deaf trainee may work by initiating discussions between training courses and regional placements;
- adapting clinical work settings where necessary, to include technical aid communications;
- promoting deaf awareness through education, training courses and workshops.

Recommendations for the second stage include providing:

- induction periods for deaf trainees. Provide information and reassurance to clients so that they can make informed decisions about seeing a deaf trainee by planning placements in advance;
- ongoing support for clinicians by creating local and regional support groups;
- forum where deaf and hearing professionals can discuss the impact of a signing environment, and assist them in appreciating others' perspectives. This should result in an environment in which both deaf and hearing people feel that they are respected and valued.

## Conclusion

The results represent the views of a wide range of clinical supervisors in the Trent Region and suggest that an increase in training and funding is necessary to enhance supervisors' awareness of deaf issues and their ability to support and feel supported when supervising a deaf clinical psychology trainee. Deaf people can make an important contribution to the service. As one supervisor said, 'I think a deaf trainee would bring an invaluable cultural experience and perspective to clinical work, which could potentially enrich the service provided by the team'.

## Acknowledgements

The Leicester Clinical Psychology training course and all supervisors in the Trent Region who took time to complete the questionnaire.

## References

Cromwell, J. & Atherton, R. (2000). Signs of change: training deaf clinical psychologists. *Clinical Psychology Forum*, 142, 32-34.

Cromwell, J. (2001). Deaf clinical psychology trainees. *Clinical Psychology Forum*, 148, 4.

Kazarian, S. S. & Evans, D. R. (1998). Cultural clinical psychology: In S. S. Kazarian & D. R. Evans (Eds.) (1998)

*Cultural Clinical Psychology: Theory, research and practice*. Oxford: Oxford University Press.

Pollard, R. Q. (1996). Professional psychology and deaf people: the emergence of a discipline. *American Psychologist*, 51, 389-396.

## Address

Grantham Health Clinic, St Catherine's Road, Grantham, Lincolnshire NG31 6TP

# Applications are invited for the posts of National Assessors

National Assessors aid in the recruitment and selection of candidates to Senior and Consultant Psychologist posts in health and social care.

National Assessors are currently sought for the following geographical and specialist areas:

- Northern Ireland – all specialities
- West Midlands – all specialities
- Wales – all specialities
- Trent – Adult Mental Health and Medical/Surgical Services
- Substance Misuse and Addictive Behaviour
- Primary Care
- Forensic
- Child and Adolescent Psychology – including paediatric psychology and paediatric neuropsychology

Training and workshops are arranged regularly, to build skills and update on relevant issues.

Any Grade B Consultant Applied Psychologist (or equivalent Professor/Senior Lecturer grade) with a minimum of five years' experience in that grade may apply to become a National Assessor. As well as contributing to maintaining the high standards of the profession, National Assessors will enjoy CPD and networking opportunities as well as the development of their professional skills.

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 [www.bps.org.uk/sub-syst/dcp/clin\\_assessor.cfm](http://www.bps.org.uk/sub-syst/dcp/clin_assessor.cfm).

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

# Debt: Who gets into it, who gets out of it and what can clinical psychology do to help?

Clare Wright, Herefordshire Primary Care NHS Trust

*This paper reviews the literature on debt and asks who gets into debt, what determines how far people get into debt, who is likely to get out of it and what contribution clinical psychology can make to this process.*

The growing social problem of personal debt and the rapid increase in consumer credit has received both widespread popular attention in the media (Lunt & Livingstone, 1991) and an increased research interest within the psychological literature (Webley & Nyhus, 2001). At a time when house prices continue to rise, shopping has become a leisure activity with credit readily available, and graduates begin their careers with heavy loans to repay, many people in Britain are suffering the social and psychological consequences of debt (Livingstone & Lunt, 1992). How, as psychologists, are we to understand or even alleviate this distress?

Debt can be defined as an obligation that a borrower is unable or unwilling to discharge and where settlement has been deferred without the seller or lender's agreement (Lea, 1999). This is distinct from credit use, which is the postponement of payment that is agreed, indeed planned, by both borrower and lender (Lea et al., 1995).

Problems with debt have been shown to have significant psychological consequences (e.g. Hartropp et al., 1987). Krause et al. (1991) argue that the perception of chronic financial stress erodes both individuals' feelings of personal control over their money and their feelings of self-esteem. Lea et al. (1987) demonstrate a positive correlation between economic distress and serious mental health problems. Hatcher (1994) found that, among patients who deliberately

poisoned themselves, those in debt were more likely to show greater suicidal intent and went on to report greater symptoms of depression and hopelessness.

Assumptions about causality, however, must be made with care (Lange & Byrd, 1998), since economic stresses may exacerbate rather than initiate mental health difficulties (Dooley & Catalano, 1986) and the psychological impact of debt may be mitigated by socio-economic status, with the mental health of poorer individuals being negatively affected to a greater extent (Lange & Byrd, 1998). Thus, although debt and mental health problems are clearly related, several factors appear to mitigate the magnitude of the effect and the exact nature of the relationship is largely unknown (Lea et al., 1987).

Three questions, identified by Livingstone and Lunt (1992), seem pertinent to this discussion.

## Who gets into debt?

The picture emerging from the debt literature suggests that, while economic variables alone predict debt quite well, psychological factors improve our ability to predict indebtedness (Webley & Nyhus, 2001).

### *Socio-economic factors*

Debt has been found to be more common among those with lower incomes and larger outgoings, and those with dependent children (Webley & Nyhus, 2001). Those in debt are consistently found to be significantly younger than those not in debt and it has been argued that this could reflect generational differences in attitudes towards debt rather than different economic demands as a function of one's stage in the life-cycle (Livingstone & Lunt, 1992).

*Attitudes towards debt and use of credit*

The 20th century witnessed a broad change in social attitudes away from views in which debt is shameful, saving is laudable and borrowing is something to be avoided. Lifestyle expectations, perceptions of luxury and need, norms regarding the acceptability and management of debt and strategies of controlling family finances have all changed (Livingstone & Lunt, 1992).

A correlation has been shown between debt behaviour and debt attitudes (Lea et al., 1993). Similarly, a strong link has been demonstrated between having more favourable attitudes towards credit and the number of credit commitments taken on (e.g. Berthoud & Kempson, 1990). Thus, those who see credit as useful and convenient do not avoid debt but rather accept it as a means of satisfying needs and wants. By contrast, those who view credit as shameful and to be avoided tend to save up in order to satisfy needs and wants and therefore do not accrue debts (Livingstone & Lunt, 1992).

*Self-control and time preference*

The ability to exercise self-control has been associated with financial decision making and the choice of whether to delay gratification, by saving for example, or to spend now, or even to borrow to buy now instead of waiting (Walker, 1996). People in debt have been found to be more present-oriented and to display low levels of self-control (e.g. Lea & Webley, 1995). However, lack of self-control may also be a consequence as well as a cause of debt. Thus, for some, getting into debt may decrease both their desire and their ability to control spending (Webley & Nyhus, 2001).

*Locus of control*

A positive correlation has been demonstrated between debt and external locus of control (Livingstone & Lunt, 1992). However, causality could run either way. Thus, people with a strong external locus of control may be more likely to get into debt, as Tokunaga (1993) suggests, or people in debt could express external locus as a result of experiencing external reasons for economic problems such as unemployment or unavoidable life events (Lea et al., 1995).

*Financial management*

Styles of financial management have been shown to play an important role in the debt status of a household (Lea et al., 1995). Those in debt are more likely to describe lacking control of their finances and making more impulsive purchases. In addition, they report using flexible strategies, varying their budgeting according to the situation, rethinking decisions if the unexpected happens whereas those not in debt are more likely to have a general budgetary plan which they stick to whatever the circumstances (Livingstone & Lunt, 1992).

It has also been suggested that people in debt tend to overestimate their future income (Seaward & Kemp, 2000). Better financial management has, in turn, been associated with being less materialistic (Walker, 1996). By contrast, being in debt appears linked to socio-psychological participation in consumer culture more generally. Thus, people in debt not only experience pleasure in consumption but also express their social worth and social relations through consumption (Livingstone & Lunt, 1992).

**What makes some people borrow more heavily than others?**

While psychological factors appear to play an important role in understanding why people get into debt, economic factors are presented as more important in determining why some owe more than others (Livingstone & Lunt, 1992). Thus, people in greater debt were found to have more limited economic resources (Webley & Nyhus, 2001).

Nevertheless, those who owe more have been shown to hold attitudes that are more favourable to credit and less hostile to debt (Berthoud & Kempson, 1990). In contrast with the comparison between people in and not in debt, those who owe more appear to find less pleasure in spending money. It appears likely that as one's debts increase, pleasure in consumption is outweighed by financial worries and problems (Livingstone & Lunt, 1992).

In addition those more in debt were found to be more present-oriented and to feel less in control of their expenditure (Webley & Nyhus, 2001).

## Why do some people repay more of their debts than others?

Disposable income has been shown to predict how far one gets into debt and is also an important predictor of how much one repays. Thus, the more income people have, the more they repay (Livingstone & Lunt, 1992). However psychological factors do have a contribution to make amongst those who have the resources to repay their debts (Walker, 1996). People who repay more report feeling more in control of their finances, viewing credit positively as an acceptable means of budgeting that allows them to have goods immediately. They neither see debt as a source of shame nor as caused by themselves, preferring instead to view it as a temporary problem within their control (Livingstone & Lunt, 1992).

## Problems with the literature

Much of the literature outlined above is based on postal surveys with low response rates and high attrition rates, and assumes that participants will self-report levels of debt honestly. Given that debt is a private and sensitive issue, questions have been raised about the representativeness of samples and the accuracy of the data obtained from these studies, since it is likely that the numbers admitting debts are less than those who actually have debts (Webley & Nyhus, 2001). In addition, the existing literature gives us much descriptive information concerning the variables associated with debt – for a commentary on debt and socio-economic status, see Berthoud and Kempson (1992) – but little about the direction of causality (Webley & Nyhus, 2001); what does exist has often been contradictory (e.g. Walker, 1996). We therefore need to develop theoretical models of debt behaviour that will integrate both economic and psychological factors (Webley & Nyhus, 2001).

## What can clinical psychology contribute?

Within the field of economics, theorists are increasingly looking towards psychology to inform research, and an understanding has emerged, that emotion often distorts financial reasoning (Nicol-Maveyraud, 2003). There is increasing evidence that people do not act alike in the same set of financial circumstances and that these dif-

ferences may be due, in part to the existence of irrational beliefs (Nicol-Maveyraud, 2003). By applying therapeutic models such as CBT, which help individuals to understand the beliefs, values and motivations underlying their behaviour, and which alleviate feelings of helplessness, clinical psychologists can play an active role in understanding and addressing debt behaviour. By encouraging better financial management this may in turn alleviate the serious psychological consequences associated with debt.

## References

- Berthoud, R. & Kempson, E. (1990). *Credit and debt in Britain. Report of first findings from the PSI*. London: Policy Studies Institute.
- Dooley, D. & Catalano, R. (1986). Do economic variables generate psychological problems? Different methods, different answers. In A. J. MacFadyen & H. W. MacFadyen (Eds.) *Economic Psychology: Intersections in theory and application*. Amsterdam: North-Holland.
- Hartropp, A., Hanna, R., Jones, S., Lang, R., Mills, P. & Schluter M. (1987). Families in debt: The nature, causes and effects of debt problems and policy proposals for their alleviation. *Jubilee Centre Research Paper No. 7*. Cambridge: Jubilee Centre Publications.
- Hatcher, S. (1994). Debt and deliberate self-poisoning. *British Journal of Psychiatry*, 164, 111–114.
- Krause, N., Jay, G. & Liang, J. (1991). Financial strain and psychological well-being among the American and Japanese elderly. *Psychology and Aging*, 6, 170–181.
- Lange, C. & Byrd, M. (1998). The relationship between perceptions of financial distress and feelings of psychological well-being in New Zealand university students. *International Journal of Adolescence and Youth*, 7, 193–209.
- Lea, S. E. G. (1991). Credit, debt and problem debt. In P. Earle & S. Kemp (Eds.) *The Elgar Companion to Consumer Research and Economic Psychology*. Cheltenham: Edward Elgar.
- Lea, S. E. G., Tarpy, R. M. & Webley, P. (1987). *The Individual in the Economy*. Cambridge: Cambridge University Press.
- Lea, S. E. G. & Webley, P. (1995). Psychological factors in consumer debt: money management, economic socialization, and credit use. *Journal of Economic Psychology*, 16, 681–701.
- Lea, S.E.G., Webley, P. & Levine, M. (1993). The economic psychology of consumer debt. *Journal of Economic Psychology*, 14, 85–119.

Lea, S. E. G. Webley, P. & Walker, C. M. (1995). Psychological factors in consumer debt: money management, economic socialization, and credit use. *Journal of Economic Psychology*, 16, 681-701.

Livingstone, S.M. & Lunt, P.K. (1992). Predicting personal debt and debt repayment: psychological, social and economic determinants. *Journal of Economic Psychology*, 13, 111-134.

Lunt, P.K. & Livingstone, S.M. (1991). Everyday explanations for personal debt: a network approach. *British Journal of Social Psychology*, 30, 309-323.

Nicol-Maveyraud, J. (2003). Mind over money. *The Psychologist*, 16, 240-242.

Seaward, H.G. & Kemp, S. (2000). Optimism bias and student debt. *New Zealand Journal of Psychology*, 29, 17-19.

Tokunaga, H. (1993). The use and abuse of consumer credit: application of psychological theory and research. *Journal of Economic Psychology*, 14, 285-316.

Walker, C. M. (1996). Financial management, coping and debt in households under financial strain. *Journal of Economic Psychology*, 17, 789-807.

Webley, P. & Nyhus, E. K. (2001). Life-cycle and dispositional routes into problem debt. *British Journal of Psychology*, 92, 423-46.

### Address

North Herefordshire Community Mental Health Centre, 62 Etnam Street, Leominster, Herefordshire HR6 8AN

ONE-DAY WORKSHOP HOSTED BY SOUTHERN BABCP BRANCH

# Mindfulness for Depression

With Professor Mark Williams, co-author of *Mindfulness-Based Cognitive Therapy for Depression*

Wednesday 3 March 2004; The Priory Hospital Marchwood, Hythe Road, Southampton SO40 4WU

Cost: £65 BABCP members, £90 others.

For details and application form please contact: Lisa James, PET Unit, Mental Health Group, University of Southampton, Department of Psychiatry (1st Floor), Royal South Hants Hospital, Southampton SO14 0YG; Tel: 02380 825704; e-mail lj1@soton.ac.uk.

*Summary:* Recent data suggests that depression is set to become one of the Western world's largest burdens of ill-health over the next 20 years. Mindfulness-based cognitive therapy aims to teach participants how to become aware of the early warning signs of relapse, and to respond to these effectively. Preliminary evidence from two RCTs suggests that MBCT is effective in reducing risk of relapse in patients with three or more previous episodes of major depression. In this workshop participants will be invited to practise mindfulness themselves in order to learn the skill. The theoretical rationale for mindfulness and the recent research literature will also be presented and discussed.

*Presenter:* Mark Williams is Wellcome Principal Research Fellow at the University of Oxford. He has been interested in cognitive models and treatment of depression and suicidal behaviour for many years. Recently he has been collaborating with John Teasdale and Zindal Segal to develop MBCT to prevent relapse and recurrence in major depression.

# 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.

Dr Nigel Roberts, Head of Psychology Services, West Cumbria Health Authority, West Cumberland Hospital, Whitehaven, Cumbria CA28 8JG; Tel: 01946 523653, Fax:01946 523546

South Birmingham Psychology Service, 208 Monyhull Hall Road, Kings Norton, Birmingham B30 2QJ; Tel: 0121 678 3400, Fax:0121 678 3401

Dr Peggy Easton, Consultant Clinical Psychologist, Psychology Department, Chichester Priority Care Services NHS Trust, 9 College Lane, Chichester, West Sussex PO19 4PQ; Tel: 01243 787970 ext. 4344, Fax:01243 815306

Dr Richard Corney, Head of Clinical Psychology Services, Psychology Department, Royal Alexandra Hospital, Rhyl, Clwyd LL18 3AS; Tel: 01745 343188 ext. 3222

Ann Pim, PA to District Clinical Psychologist and Director of Clinical Services, Greybury House, Bridge Sreet, Walsall WS1 1EP; Tel: 01922 858515/ 858450

Ingolf Gudjonsson, Clinical Psychology Advisor, Adult Psychology Service, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT; Tel: 01302 734795/ 366666 ext. 4172

Peter Watson, Head of Psychological Services, Combe House, George Eliot Hospital, College Street, Nuneaton, Warwickshire CV10 7DJ; Tel: 01203 350111; Fax:01203 353744

Lindsay Royan, North East London Mental Health Trust, The Petersfield Centre, Petersfield Avenue, Harold Hill, Romford, Essex RM3 9PB; Tel: 01708 796464, Fax:01708 796475

Juliana C. Macleod, Clinical Psychology Services Manager, Pluscarden Clinic, Dr Gray's Hospital, Elgin IV30 1SN; Tel: 01343 543131 ext. 77499

Ilona Kruppa, Lead Psychologist, Mental Health Directorate, Rampton Hospital Authority, Retford, Nottinghamshire DN22 0PD; Tel: 01777 247312

Gail Scothern, Head of Psychology Service for Older People, Directorate of Psychiatry for the Elderly, Towers Hospital, Gypsy Lane, Leicester LE5 0TD; Tel: 0116 246 0460 ext. 2662

Ron Tulloch, Director of Psychology and Clinical Development, The Coach House, Stockton Hall Psychiatric Hospital, Stockton on the Forest, York YO3 9UN

Keith Homfray, Head of Psychology Services, Department of Clinical Psychology, 314-316 Oldham Road, Royton, Oldham OL2 5AS; Tel: 0161 624 0420 ext. 5350

Pam Durrant, Head of Clinical Psychology Services, North Devon Hospital, Raleigh Park, Barnstaple, Devon EX31 4JV; Tel: 01271 322442/322789

Martin Willmott, Lead Psychologist, Worcestershire Mental Health Partnership NHS Trust, Smallwood House, Church Green West, Redditch, Worcestershire B97 4BD; Tel: 01527 488637

Keith Piper, Head of Clinical Psychology Services, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PR30 4ET; Tel: 01553 613848, Fax:01553 613863

Deirdre MacIntyre, Principal Clinical Psychologist, Child Psychology Service, Eastern Health Board, Kill Child and Family Centre, Co. Kildare, Ireland; Tel: 00 353 45 877731, Fax:00 353 45 877512

Brian Stanley, Head of Psychology Services Learning Disabilities, Pollits House, Westwood Hospital, Cooper Lane, Bradford, West Yorkshire BD6 3NL

Carole Bosanko, Head of Psychology Department, East Cheshire NHS Trust, Macclesfield District General Hospital, West Park Site, Victoria Road, Macclesfield, Cheshire SK10 3BL; Tel: 01625 663547, Fax:01625 663546

Christine Richards, Head of Forensic Psychology, John Howard Centre, 2 Crozier Terrace, Hackney, London E9 6AT; Tel: 0181 919 8354

Dr Pauline McGill, Head of Psychological Health Care, Barnsley Community and Priority Services NHS Trust, 11/12 Keresforth Close, off Broadway, Barnsley S70 6RS; Tel: 01226 777914, Fax:01226 287604

Cathy Thomas, Consultant Psychologist, St John's House Hospital, St John's House, Lion Road, Palgrave, Diss, Norfolk IP22 1BA; Tel: 01379 643334; e-mail: cthomas@partnershipsincare.co.uk

Padhraic Dolan, Head of District, Clinical Psychology Department, Level 2, Strathmore House, Brouster Gate, East Kilbride G74 1LF; Tel: 01355 249470

David McMahon, Head of Clinical Psychology, East Midland Centre for Forensic Mental Health, Arnold Lodge, Cordelia Close, Leicester LE5 0LE; Tel: 0116 225 6040, Fax:0116 225 6127

John Rowe, Learning Disabilities Service, City and Hackney Community NHS Trust, St Leonards Hospital, Nuttall Street, London N1 5LZ; Tel: 020 7301 3086

Mary Leavy, Head of Clinical Psychology Service, Parkwood, East Park Drive, Blackpool FY3 9HG; Tel: 01253 306261, Fax:01253 306264

Katherine Carpenter, Head of Department, Oxford Department of Clinical Neuropsychology, Russell Cairns Unit, The Radcliffe Infirmary, Oxford OX2 6HE; Tel: 01865 224264, Fax:01865 727297, e-mail: Katherine.Carpenter@orh.nhs.uk

Tim Cate, Head of Psychological Health Service, St Luke's Hospital, Marton Rd, Middlesbrough TS4 3AF

Dr Sally Furnish, Head of Psychology Services (North Mersey), Mersey Care NHS Trust, Mill Lane, Rathbone Hospital, Liverpool L9 7JP; Tel: 0151 250 3021/3035, Fax:0151 220 4291, e-mail: S.Furnish@liv.ac.uk

Andrew Rapley, Head of Child Psychology, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH; Tel: 020 8746 8972

Simon Jakes, MacArthur Metal Health Service, 6 Browne Street, Campbelltown, New South Wales 2560, Australia; e-mail: simon.jakes@swsahs.nsw.gov.au

Jan Aksnes, Acting Head of Clinical Psychology, Argyll and Bute Hospital, Lochgilphead; Tel: 01546 604904, Fax:01546 604915

Kath Bland, Head of Psychology Services, South Tyneside District Hospital, Harton Lane, South Shields NE34 0PL; Tel: 0191 202 4060, Fax:0191 202 4098

Teresa O'Mahony, Senior Clinical Psychologist, Hibernian Building, 13-14 Main Street, Skibbereen, Co. Cork, Ireland; Tel: 00 353 28 40580, Fax:00 353 28 23172, e-mail: omahonyt@shb.ie

Siri Wooster, Consultant Clinical Psychologist, CAMHS (East Herts), Hoddesdon Health Centre, High Street, Hoddesdon, Hertfordshire EN11 8BE; Tel: 01707 365054 or 01992 465042

Ivan Burchess, Consultant Clinical Psychologist, Head of Clinical and Counselling Psychology Services, 101-103 Bond House, St John's Square, Wolverhampton WV2 4AX; Tel: 01902 445715, Fax:01902 445491, e-mail: ivan.burchess@wolvespct.nhs

David Spellman, Consultant Clinical Psychologist, Pennine House, Burnley General Hospital, Casterton Avenue, Burnley BB10 2PQ; Tel: 01282 474760

Mrs Rebecca J. Davies, Consultnat Clinical Psychologist, Head of Teeswide CAMHS Psychology, Newberry Centre, West Lane Hospital, Aclam Road, Middlesbrough TS5 4EE

Thembi Sibisi, Head of Psychology, Bell House, Le Grand Bouet, St Peter Port, Guernsey GY1 2SB; Tel: 01481 701441; Fax:01481 711108; e-mail: tsibisi@health.gov.gg

Michael Heap, Lead Psychologist, Nottinghamshire Healthcare NHS Trust, Wathwood Hospital Regional Secure Unit, Gipsy Green Lane, Wath-Upon-Dearne, Rotherham S63 7TQ; Tel: 01709 870800

Dr Mary Browning, Head of Psychology Services, Park Street Clinic, Newtown, Powys SY16 1EG; Tel: 01686 617388; Fax:01686 617387

Jenny West, Consultant Clinical Psychologist, Adults with Learning Disabilities, Local Health Partnerships NHS Trust (West Suffolk Locality) Stourmead House, Stourmead Close, Kedington, Suffolk CB9 7PA; Tel: 01440 715900

Dr Mary Jackson, Clinical Director, Mersey Care NHS Trust, Hesketh Centre, 51-55 Albert Road, Southport PR9 0LT; Tel: 01704 383007

Steve Jones, Head of Child & Family Division, Psychological Health Sheffield, Sheffield Children's NHS Trust, Western Bank, Sheffield S10 2TH; Tel: 0114 226 7812; Fax: 0114 271 7296; e-mail: Steve.Jones@sch.nhs.uk

Maggy Ruppert, Norwich City Locality (Norfolk Mental Health Care Trust), Adult Services; and David Fowler, Early Intervention; Tel: 01603 201494; e-mail: magruppert@esco.net or d.fowler@uea.ac.uk

Dr Carol Leckie, Programme Director CAMHS, Beech House, Margaret Street Clinic, 15 Margaret Street, Wakefield, West Yorkshire WF1 2DQ; Tel: 01924 327604; Fax: 01924 327602; e-mail: carol.leckie@swyt.nhs.uk

Dr Clare Kevis, Consultant Clinical Psychologist, Clare House, St Andrew's in Essex, Pound Lane, North Benfleet, Essex SS12 9JP; Tel: 01268 723800; Fax: 01268 723839; e-mail: ckevis@standrew.co.uk

Dr Naomi Murphy, Consultant Clinical and Forensic Psychologist, Dangerous and Severe Personality Disorder Service, HMP Whitemoor, Longhill Road, March, Cambridgeshire PE15 0PR; Tel: 01354 602567; e-mail: naomi.murphy@hmps.gsi.gov.uk

*To place a new entry - or remove an old one - please write to Jonathan Calder, The British Psychological Society, 48 Princess Road East, Leicester LE1 7DR; Fax: 0116 247 0787; e-mail: joncal@bps.org.uk*

*Do you want to know more about the clinical psychology training courses you are applying to? Then you need...*

## **The Alternative Handbook 2004 for Training Courses in Clinical Psychology**

For a copy of the Alternative Handbook 2004, please send a cheque for £4.50 (£5 for an overseas address), made payable to the *Affiliates Group of the DCP*, with your name and address (and BPS number if you have one) on the back, together with an A5 self-addressed envelope (no stamp required) to:

DCP Affiliates Alternative Handbook Request, St Andrews House, The British Psychological Society, 48 Princess Road East, Leicester LE1 7DR.

# Book Cover

## **Complexity and healthcare: an introduction**

*edited by Kieran Sweeney and Frances Griffiths*

Radcliffe Medical Press, 2002, £24.95

Everything relates to everything else, there are no obvious solutions. Even if there were, they would not be straightforward. This message running through a multi-authored text should interest the clinician wondering how it is that, no matter how much money is pumped into the NHS, not a lot seems to result (apart from fresh fields of blooming acronyms).

Griffiths on primary healthcare research, and Sweeney and Cassidy for much of their chapter on clinical governance, are noteworthy. The other five authors also have practical insights, and Kernick should be singled out for a down-to-earth definition of the 'garbage-can model' of healthcare organisation, and 'the process known as disjointed incrementalism or muddling through'.

Although this book is worth reading more than once, the goal of integrating mathematical theory and clinical understanding remains elusive. At times this disjointed incrementalist could not help being reminded of the ingenious critic described

in *The Pickwick Papers*. Required to review the subject of Chinese metaphysics, he consulted encyclopaedia entries for 'China' and 'Metaphysics', and combined the two.

## **Jeff Garland**

## **Dreams that turn over a page, paradoxical dreams in psychoanalysis**

*Jean-Michel Quindoz*

Brunner-Routledge, 2002, £16.99

This brief book deals with a particular type of dream that may occur a few times in the course of analysis. The author bases his ideas on classical Freudian dream analysis and Kleinian psychoanalysis, and a fairly thorough knowledge of these is assumed. The dream's content seems to indicate a regression. However, the dream is in fact a retrospective working through and illuminates past conflicts, which can now be faced. The author details how this particular type of dream may be recognised and how it should be worked with in analysis.

Although this book is brief, it could have been even more concise as it does appear to be a laboured elaboration of previous journal articles. Despite this, if you have a specific interest in dreams in psychoanalysis this will make an interesting little book to dip in and out of. However, if you are looking for a general book on dreams or on the psychoanalytic understanding of dreams, this is not the book for you.

## **Annie Rust**

## **Arts therapies and progressive illness: nameless dread**

*edited by Diane Waller*

Brunner-Routledge, 2002, £16.99

This compilation of papers focuses on the relevance and application of non-verbal arts therapies such as art, dance, music and movement to dementia. It emphasises how arts therapies can be utilised in maintenance and therapeutic endeavours with people diagnosed as having

Alzheimer's, Parkinson's and Huntington's diseases. The authors give excellent and clear descriptions of the clinical symptomatology of these different forms of dementia. However, I found the text unnecessarily repetitive, particularly when describing clinical symptoms such as those exhibited by people who have Alzheimer's disease.

The book has a patchwork feel to it. Its main strength lies in descriptions of the creative and bold initiatives being undertaken by arts therapists in this specific area of progressive illness. Unfortunately, most of the chapters are anecdotal in nature and many have been poorly edited. I found the writing irritatingly uneven and many of the chapters are poorly referenced. Apart from one empirical study, the authors displayed a lack of critical evaluation of their work. It is of some interest as an introductory reader, but I would not happily recommend this book to researchers or clinical psychologists who have an interest in arts therapies and dementia.

**Roy Bailey**

**Working inter-culturally in counselling settings**

*Aisha Dupont-Joshua*

Brunner-Routledge, 2003, £15.99

This is a much-needed volume for practitioners working with people from diverse cultural backgrounds. The editor and some authors have strong links with the Nafsiyat Intercultural Therapy Centre, and the book seems to take over where Kareem and Littlewood (1992) left off. Each of the authors offers an interesting psychological analysis of the process and effects of racism within the therapeutic encounter, and suggests practical advice to address this.

Two contributors, Ochieng and Mohammad, offer alternative conceptualisations of mental distress in their specific areas of expertise – clients of African descent and females of Asian Muslim background respectively. Their advice on how to formulate and engage with the client's world, and the use of case study material, are particular

strengths of the book. A further chapter concerns the adaptation and application of Western structures, such as assessment and supervision, within communities which are new to formalised therapeutic models, with the example illustrated coming from the former Soviet Union. Also included are specialised areas such as counselling with prison and probation clients and within social services contexts.

Overall, the book is a fascinating read for practitioners interested in developing the accessibility and utility of their therapy services for minority ethnic clients. It would also appeal to those interested in analysis of the therapeutic relationship as a reflection of power dynamics, both within the room and at a societal level. I would consider the text essential reading for psychologists and experienced practitioners or supervisors who would like to expand their skills for working with people from culturally diverse backgrounds

**Clair Clifford**

*References*

Kareem, J. & Littlewood, R. (Eds.) *Intercultural Therapy: Themes, interpretations and practice*. Oxford: Blackwell Scientific Publications.

**Essentials of WJIII Cognitive Abilities**

**Assessment**

*Alan S. Kaufman and Nadeen L. Kaufman*

Wiley, 2003, £25.95

This forms part of the series in Essentials of Psychological Assessment. As its title suggests, it provides everything you need to know about the WJIII Cognitive Abilities Assessment (WJIII COG). This is described as a battery of tests for measuring cognitive abilities and related aspects of cognitive functioning. The abilities that it measures are auditory working memory, general information, retrieval fluency, auditory attention, decision speed, rapid picture naming, planning and pair cancellation.

Chapter 1 provides a general overview of how the tests developed over time. Chapters 2 to 4 cover administration, scoring and interpretation of the tests. Chapter 5 gives a detailed analysis of

the strengths and weaknesses of the WJIII COG organised along six criteria: theory, test content, administration and scoring, interpretation, technical characteristics and quality of materials. Chapter 6 examines the clinical use of discrepancy procedures and chapter 7 provides illustrative case reports which give an idea of the scope of the test applications.

I was interested to read this from the point of view of finding out more about another tool for psychometric assessment. The book will act as a good resource for the keen psychometrician, in particular for clinicians who work in either educational psychology or clinical child psychology.

**Carol Valinejad**

#### **Books available for review**

Bennett-Goleman, T. (2003). *Emotional Alchemy: How your mind can heal your heart*; Rider.

Bogue, B. M., Nandi, A. and Jongsma, A. E. Jr. (2003). *The Probation and Parole Treatment Planner*; Wiley.

Cooper, M. (2003) *Essential Therapies*; Sage.

Graham, H. L. (2004). *Cognitive-Behavioural Integrated Treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems*; Wiley.

Grainger, R. (2003). *Group Spirituality: A workshop approach*; Brunner-Routledge.

Hawkins, J. (2002). *Voices of the Voiceless: Person-centred approaches and people with learning difficulties*; PCCS Books.

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.

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.

van Löben Sels, R. (2003). *A Dream in the World: Poetics of soul in two women, modern and medieval*; Brunner-Routledge.

*If you are interested in reviewing any of these books, please write to the Book Reviews Editor: Dr Arlene Vetere, Department of Psychology, Surrey University, Guildford GU2 7HX*

*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.*

**2 December 2003**

# **Advertise in *Clinical Psychology***

Contact Jonathan Calder on 0116 252 9502 or  
joncal@bps.org.uk

*Notices of Division, SIG, Faculty and Branch events appear free of charge*

*November 16*

Nigel round for Sunday lunch. Still fuming over assertiveness/boss/getting fired interface. Offered to look up redundancy counselling on Google. N's already been there. 16,600 sites. Called one counsellor who kept saying that N sounded angry. N said that he had the curious feeling that he wasn't sure who made him more angry now – his ex-boss or the parasites who feed off redundancy. Thinking of setting up a Workers Against Counsellors website. Alison asked what the union had to say. N said he had dropped his membership pre-Blair and not thought it would need renewing. Glum silence all round broken by Alison asking how I had got on with the Google search on pregnancy.

*November 16 (later)*

Even A beginning to look bored with amount of material I've come up with. 7,640,000 sites. No end of pregnancy calendars, ads for TENS machines and the rest. FitPregnancy.com offers some myth-busting: 'The truth about hair dye, stretch marks, the 40 week glow and more.' A said that she hadn't heard of most of the myths and didn't know a sane woman who thought that pregnancy produced a contented 'glow'. The site gives access to some people called 'lactation consultants'. Nigel gives his apologies.

*November 21*

Still on pregnancy. Visited the Planned Parenthood Federation of America site and called up 'How to talk to your child about sexuality'. They have a Spanish version.

*November 22*

Pub with Nigel. Told him about sexuality page. Asked what I had said to Tim. Said that Tim looked alarmed last night when I sat on the edge of the bath and started up 'Buenos noches'. Found the whole thing easier in Spanish as Tim couldn't understand it at all.

*December 1*

Talking with Alison about discussing sexuality with Tim. Asked her how she did it. Said she just

## Self-help



answered him straight whenever he asked. Said she had told him where the new baby had come from.

*December 3*

Session with clin psych. Told her about A's truthfulness with Tim. CP asked what the problem was. Said that I had told Tim that babies were delivered by storks – in Spanish. CP asked how I'd been told. Can barely remember. Think my dad made some reference to dogs mating and mum said, 'It's not quite the same,' with a glare. *The Joy of Sex* helped – except it didn't explain about the fumbling, worry, mess, pain and a variety of less than joyful things. CP asked how things are now...

*December 10*

Worried about talking straight to Tim. Took AOL 'Are you a pushover parent?' test. I am. Alison says my version of firm love makes Mother Teresa look like Attila the Hun.

*December 21*

Out with Graham and June. Lots of 'I hope you're not too tired' comments to A. Says me being off work has been really helpful and brought up firm love stuff. G reckons that all this advice on how to balance criticism with praise and be simultaneously authoritative and caring is driving parents round the bend. Says it's basically 'everything in moderation' turned in to a zillion websites, self help books and professional pay packets. J says that 'everything in moderation' is an oxymoron. Wonder what Spanish for masturbation is.

*Felix Q.*

# The Alternative Page

*A bimonthly look by Nigel Mills at some of the issues and therapies which can complement a psychological perspective*

## The dangers of cheese on toast

Cheese on toast. Pizza. Pasta with a cheese sauce. Cheese sandwiches. Cheeseburgers. Breakfast cereal with milk. A slice of cake with a cup of hot chocolate or a glass of milk. Doughnuts. Croissants. Crumpets and butter. Bagels with butter...

The myriad ways in which we combine the basic ingredients of wheat and dairy are a tribute to human creativity. However, there is a rumbling in the digestive processes of academic biochemistry. It seems that our increasing daily dependence on wheat and dairy might be linked to our increasing levels of problems described as autism and related conduct.

Shaw (2002) reviews several studies which describe how children with a diagnosis of autism, and adults with a diagnosis of schizophrenia, have elevated levels of peptides in their urine resulting from the incomplete breakdown of certain proteins from milk and wheat. (Dohan 1969; 1976; Reichelt, 1990; Shattock, 1990) Removal of these proteins, either through diet or dialysis, apparently results in an improvement in psychological functioning.

Peptides from gluten and casein are important because they react with opiate receptors in the brain, thus mimicking the effects of opiate drugs like heroin and morphine. The peptide from wheat is called gluteomorphin (or gliadorphin) and from milk, caseomorphin. Biochemically, the peptides are quite similar and they require the same enzyme to break them down: dipeptidyl peptidase IV (DPP IV). Shaw (2002) describes how production of this enzyme can be inhibited by other substances, particularly the MMR vaccine.

Casomorphin and gliadorphin have been shown to react with the temporal lobes, which are involved in speech and auditory integration (Sun et al., 1999). Because the milk and wheat peptides function as opiates, a withdrawal effect may occur when these food are removed from

the diet. Gradual withdrawal from these foods is therefore recommended for sensitive individuals.

So, next time you feel those cheese on toast cravings coming on, just pause and reflect, is this really an opiate addiction I am struggling with here? I have written to my local NHS addiction service suggesting they set up a separate cheese on toast service, but so far have had no response.

### References

- Dohan, F. C. (1969). Relapsed schizophrenics: More rapid improvement on a milk and cereal free diet. *British Journal of Psychiatry*, 115, 595.
- Dohan, F. C. (1976). The possible pathogenic effect of cereal grains in schizophrenia: Celiac disease as a model. *Acta Neurologica Scandinavica*, 31, 195.
- Reichelt, K. (1990). The effect of gluten free diet on urinary peptide excretion and clinical state in schizophrenia. *Journal of Orthomolecular Medicine*, 5, 1223-1239.
- Shattock, P. (1990). Role of neuro peptides in autism and their relationship with classical neurotransmitters. *Brain Dysfunction*, 3, 328-345.
- Shaw, W. (2002). *Biological Treatments for Autism and PDD*. Lenexa, KS: Great Plains Laboratory ([www.greatplainslaboratory.com](http://www.greatplainslaboratory.com)).
- Sun, Z. et al. (1999). Beta-Caseomorphin induces Fos like reactivity in discrete brain regions relevant to schizophrenia and autism. *Autism*, 3, 67-84.

**Nigel@chigung.fsnet.co.uk**