Clinical Psychology Forum

Special Issue: Psychology & Psychiatry: Bridging the gap
Clinical Psychology Forum

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

Clinical Psychology Forum is published monthly and mailed on the penultimate Thursday of the month before the month of publication.

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.
I ADMIT I’m a bit anxious about this special issue of CPF. I spend a bit – well, a lot – of time on Twitter (@steweatherhead/@cpfeditor) and have noticed some contention in the public domain around issues which concern both clinical psychology and psychiatry. Issues such as whether diagnosis acceptable/valid or not, whether mental health services are paternalistic/oppressive, which are the ‘best’ forms of intervention for people who are struggling with their emotional well-being, the pros and cons of the recovery agenda… At times it can seem as though issues such as this have the potential to exacerbate the differences between professions, and lose sight of the many great things that can unite individuals and help grow mental health services for the better.

It is with this in mind that I contacted some ‘tweeps’ to see if they might be interested in contributing to a special issue focused on bridging the gap between some of the underpinning philosophies and frameworks upon which clinical psychology and psychiatry are built. All but one of the authors in this issue are Twitter users whom I invited via Twitter. Social media is a really great leveller and I feel pleased to have been able to include a diverse range of individuals as contributors. I admit I don’t always agree with their individual views, but wouldn’t life be boring if we all agreed on everything? However, I do think they all have some important things to say. I hope their work will inspire you and others. I hope it sparks debate. Most of all, I hope it is received with the good intention on which this issue was developed: To foster collaboration, regardless of whether or not we always agree with the people with whom we’re collaborating.

Simon Muide’s article is the only one which did not result of direct contact through Twitter, though Twitter was the catalyst for it. Bear with me whilst I tell the circuitous story. This year I am fasting a different thing each month. So far, I’ve given up things like chocolate, tea (that was hard!), meat, and for one month I gave up my professional signature on e-mails. This came from a discussion in which I became aware that we often debate the appropriateness of terms such as service user and patient, but rarely do we discuss the impact of using the titles given to us by our employers. I decided to give mine up for a month and asked Twitter users for ideas of what to replace it with. Simon spotted one of them in my signature line and enquired about it. The conversation led to the development of what has turned out to be a very wonderful article written by Simon. I would encourage you to read Simon’s article first, then explore the rest of the publication.

I hope you enjoy this special issue. As always, your views are welcomed. The easiest way to contribute to the correspondence section is to e-mail Sue (s.j.maskrey@sheffield.ac.uk) or me (s.weatherhead@lancaster.ac.uk), and we’ll do our best to keep the conversation going within the pages of CPF. Our DCP membership affords us all a stake in this publication, let’s use it as another tool from which we can further develop ourselves and our profession.

Stephen Weatherhead
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Neuropsychology Competitions
The Encephalitis Society is dedicated to creating opportunities for students with an interest in Encephalitis and we are now accepting entries into our annual competitions. See below for the brief on each competition or visit our website for full details on how to enter.

Good luck!

The Johnny Sutton Neuropsychology Student Travel Bursary 2014
Submission Deadline: 1st October 2014
Prize: £500

Open to: Psychology students at both undergraduate and postgraduate levels (e.g. MSc/DClinPsy/DEdPsy/PhD) interested in Encephalitis to apply for their Psychology Student Travel Bursary.

The bursary can be used to present a project on Encephalitis at a conference (outside the UK), or elective travel, or to visit a laboratory, research or clinical group working on Encephalitis, if it supports some aspect of the students work in this area.

Neuropsychology Essay Prize
Submission Deadline: 1st October 2014
Prize: £500 - Runner Up Prize: £250

Open to: Psychology students at postgraduate level (e.g. MSc/DClinPsy/DEdPsy/PhD) interested in Encephalitis to participate in the Neuropsychology Essay Prize.

A prize of £500 will be awarded for the best student essay on any aspect of the neuropsychology of Encephalitis, which is an original piece of work, thought-provoking, comprehensible to a lay audience, and appropriate for publication on the Encephalitis Society website. If there are sufficient quality submissions a runner up prize of £250 will also be awarded.

www.encephalitis.info/competitions
Caption competition

This month’s caption competition features some serious looking men pointing excitedly.

All you have to do is use your skill and judgment to come up with a clever or funny clinical psychology related caption for the photo and send it to the Editor via Twitter (@cpfeditor) using the hashtag #cpfcaption. The closing date is 19 September 2014.

We will publish the winning caption and the sender’s Twitter username in the November issue.
ARE YOU taking advantage of the extremely low registration rates for this year’s DCP Annual Conference?

This year’s conference is highly subsidised by the Division to enable as many people as possible to attend, so why not book now?

Reduced conference rates
The conference will take place in Glasgow at the Raddison Blu Hotel on 3–5 December.

Prices start at £55 for single day attendance or £69 for all three days. Members Day prices start from just £5 and include the opportunity to attend and participate in the AGM, where this year’s most significant new DCP publications will be launched.

Registration is now open!
Fees include full access to all sessions, access to our exhibition and poster sessions, conference materials, refreshments and lunch. Early bird rates apply until 22 October 2014. All rates will increase by £20 after this date.

Note that this is a non-residential conference and accommodation is not included in the conference fees.

Conference theme
The theme of this year’s conference is: ‘Standing up and Speaking Out: Clinical Psychology and Social Context’ – something psychologists are very good at doing on behalf of their clients and about their work. We really need
to celebrate excellence in clinical psychology, and this day does just that by looking at current work being done by psychologists across the lifespan.

**Members Day**
The conference starts on Wednesday with Members Day, where you will be welcomed by a representative of the Scottish Parliament. Speakers from the DCP Faculties will then present on key issues under this theme, such as:

- **From trees of life to forests of hope:**
  - _Black and minority ethnic service users leading the way_ (Faculty of Psychosis and Complex Mental Health);

- **Positive behaviour support: An approach for people across all care groups** (Faculty of Intellectual Disability);

- **Clinical psychology and social context:**
  - _A Scottish older adult perspective_ (Faculty of the Psychology of Older People).

There will also be presentations from: the Faculty of Clinical Health; the Faculty of Children, Families and Young People; and the Faculty of Leadership and Management. The latter will address issues in relation to the Francis report.

The day will end with a free public lecture by Professor Michelle Ryan from the University of Exeter.

The conference will also include streams from the Leadership & Management Faculty and the Faculty for Addictions.

**Thursday and Friday**
The following two days have some excellent keynote speakers and a great line up of symposia featuring:

- **Professor Alexander Haslam**
  *University of Queensland*

- **Mary Boyle**
  *Professor Emeritus of Clinical Psychology, University of East London*

- **Professor Michelle Ryan**
  *University of Exeter*

Submissions for sessions have now closed but you can submit poster presentations until 2 October.

Go to [tinyurl.com/dcpconf2014](http://tinyurl.com/dcpconf2014) for further information.

**Cath Burley**
*Director, Membership Services Unit*
Twitter: @cathburley
As a practising consultant child and adolescent psychiatrist and active member of the critical psychiatry network, I am aware that there are many ethical dimensions embedded in the ‘First do no harm’ Hippocratic oath that doctors and health care professionals are expected to abide by. Here, I consider the impact of our decisions well beyond our professional self-interest: from how what we do may harm patients, to potential harms wrought by our beliefs and practices in the cultural milieu at large.

Psychologists and psychiatrists, along with psychotherapists and other allied professionals, work in contested territories. The arena of mental health is dominated by uncertainties. We are influenced by diverse factors that span the panoply of ‘what makes us human’, including our biology, psychology, social circumstances, cultural experiences, politics, and so on. In recent decades psychiatrists and psychologists have sometimes found themselves in dispute about which profession has a better grasp and understanding of what is happening when this human experience is disrupted, to a point where professional assistance is needed. However, a step back from this interprofessional rivalry suggests, to me at least, that more importance lies in an examination of the ideas and meaning-making frameworks we use, rather than our assumptions about intraprofessional ideologies. Here it is possible to identify different ‘community of interests’ which have emerged that join particular psychologists and psychiatrists together in either supporting current hegemonic beliefs, practices and service structures (often referred to as the ‘medical model’) or critiquing it and favouring more psychosocially and relationally orientated models.

One such community of interest is reflected in recent high profile publications. An article authored by 29 members of the Royal College of Psychiatrists in the British Journal of Psychiatry argued that the evidence base points toward the need for an important paradigm shift in practice away from the technically-based medical model toward the primacy of contexts, meanings and ethics (Bracken et al., 2012). At a similar time and independently, a group of psychologists published, in response to the mounting concern about the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), an influential position statement challenging the basis of medical model diagnosis driven thinking (Division of Clinical Psychology, 2013). Many of the psychologists and psychiatrists in these two groups are now working together to promote debate within their professions and more widely on the evidence and ethics of current practice models and urging the widespread adoption of alternatives to the medical model.

The arguments note that the evidence-base finds little scientific support for the current approach to organising practice and services. The belief that our subjectively constructed diagnostic frameworks help us choose a technically specific intervention is now being shown to be based more on wishful thinking than the findings of good outcome studies. The belief that treatments for mental health problems resemble giving insulin for diabetes is quite simply wrong.

For example, take the most commonly made diagnosis in mental health – that of depression. Available evidence does not support the idea that depression is caused by any chemical imbalance; anti-depressants appear to create rather than ameliorate a chemical imbalance (Moncrieff, 2008).
Indeed, despite having important psychoactive properties, meta-analyses of drug treatments for depression demonstrate minimal differences between drugs and placebos (Kirsch et al., 2008). The other physical treatment used sometimes, that of electroconvulsive therapy (ECT), has a similarly poor evidence base, with reviews of studies comparing real with ‘sham’ ECT, highlighting the importance of non-technical aspects of treatment. The most recent systematic review did not find a significant difference between real and sham ECT after the treatment period (Read & Bentall, 2010).

A similar lack of specificity emerges from the literature on psychotherapy. Cognitive behavioural therapy (CBT), the form of psychotherapy most widely promoted today, is premised on the idea that rectifying faulty cognitions in depression leads to recovery. However, several studies have shown that most of the specific features of CBT can be dropped without adversely affecting outcomes (Jacobson et al., 1996). The evidence that non-specific factors, as opposed to specific techniques, account for nearly all the change in therapy is overwhelming. Extra-therapeutic factors and the impact of the therapeutic relationship accounts for nearly all the variance in outcomes across the psychotherapy field, with matching therapeutic modality to diagnosis having a clinically insignificant impact on outcomes (Wampold, 2001; Cooper, 2008).

Why is this knowledge not known about or in the public consciousness? How far are our professions complicit in maintaining concepts and practices that are not compatible with the evidence? How ethical is it to avoid engagement with these vital questions and carry on doing what we do just because it is what we have always done? How much of this intellectual malaise is due to putting professional self-interest above patients’ best interests?

Both the professions of psychology and psychiatry are complicit in largely avoiding these questions of ethics and science. For example:

- What are the consequences on individuals of our preferred framework for making sense of their dilemmas and struggles (e.g. the impact of telling someone they have a potentially lifelong disorder or using diagnosis as an explanation without producing any independent evidence demonstrating what is wrong with them psychologically or physiologically)?
- What impact will selling the technical model have in people’s lives outside the consulting room (e.g. keeping them at a school that is unsupportive through using medication, or the potential for stigma, discrimination and reduced life chances that accrue from carrying a psychiatric diagnosis)?
- Should we contribute to detaching subjective experiences of distress from real life events that have and maybe continue to happen in their lives (e.g. diagnoses like attention deficit hyperactivity disorder and autism rely on categorising outward behaviours that may obscure experiences of trauma, alienation and broader relationship difficulties; in other words, more context-based meanings)?

At the local social level we can also interrogate current practice for important practice and ethical dilemmas. What impact does our practice have in local communities? For example, will having one child apparently calm from medication spur more referrals from that school and more children considered needing medication? Or what happens to the self-belief of parents and teachers in their ability to confidently and competently raise children when surrounded by messages that experts ‘know’ better? These local social dynamics also reflect and are reflected on by our cultural common sense that has come to accept that the diagnoses we use reflect some naturally occurring logical categories for which there are specific technical interventions. What does this professionalising of the vagaries of human experience have on our cultural models of childhood, family life and emotional experience? To what degrees are our models culturally specific (e.g. technical, individualistic, commodified)? At the political level, how far
are human rights issues rendered invisible? How far are economic outcomes turned into medicalised individual failings, where socio-economic oppression gets read as failures of the mind? It is worth recalling that a major spur for developing the Improving Access to Psychological Therapies (IAPT) project was the belief that depression causes unemployment and providing CBT to treat depression will lead to improved employment levels.

The above are just a small sample of the type of ethical dilemmas haunting the scientifically failed enterprise of trying to categorise human mental suffering and behavioural variation into decontextualised intra-individual technical processes. According to many, the harms already perpetrated by well-meaning attempts to help is already catastrophic for those who end up being diagnosed as having chronic mental illness. The outcomes for this group are frightening. Increasing numbers are falling into this category, and rates of long-term recovery are getting worse, not better. This group face a likelihood of dying some 15–20 years younger than the rest of the population. An increasing number of people are on disability benefits for a mental health reason, with over half of in receipt of this because of ‘depression’. There is an increase in use of both medication and psychological therapies, with little evidence that this is leading to any improvement in their long-term outcomes. It is hard to imagine such a record of harms could be tolerated in any other branch of healthcare, and it is hard to imagine how an ethical perspective can tolerate our use of the failed medical model diagnostic paradigm in mental health care any longer. It is time to reach beyond diagnostic dependence, to embrace models that prioritise meanings, contexts and values, with service users’ voices and a recovery orientation central. It’s what the scientific evidence and a ‘First do no Harm’ ethical perspective says we should do.

Professor Sami Timimi (@stimimi)
Consultant Child and Adolescent Psychiatrist, Horizon Centre, Lincolnshire Partnership NHS Foundation Trust; stimimi@talk21.com

References
My e-mail in-box is cluster-bombed pretty much every day, and most of this electronic ordinance is related to my role as a Service User and Carer Representative in several different though interconnected worlds. Someone I know, who is otherwise normally admirably conscientious, occasionally deletes everything in their in-box to see what happens and what fallout there may or may not be. Their experience is that there has rarely been any particularly undesirable consequence of their deliberate decision to create the opportunity to ‘reboot’ their correspondence, and effectively screen out anybody who doesn’t chase things up. What may appear to be a somewhat risky professional strategy actually serves to actively invite the creativity and spontaneity which can bring about promising new ideas and approaches to their practice in their personal and professional relationships.

I usually read mine, though I do have the perhaps commonplace approach of applying a particular mental filter to the subject line, opening it up, and then skimming the content to check if there is anything of any relevance or interest to me. However, this strategy can lead to missing out on apparently tiny details, verbal ‘attachments’, which when opened up can be very interesting indeed.

A typical professional signature usually denotes title, position and role. I spotted one which was most unusual, so chose to enquire why the originator chose to use it. This article fell out of our subsequent discussion.

Why goodbye could be the new hello
The Beatles did pretty well celebrating this seeming paradox, with their 1967 ‘Hello, Goodbye’ song. When quizzed about its meaning, Paul McCartney said: ‘The answer to everything is simple. It’s a song about everything and nothing. If you have black you have to have white. That’s the amazing thing about life.’

All of our life experiences are inextricably related, though perhaps we tend to consciously or otherwise default to our favoured state, as it is often what we think is the most comfortable and logical place to be. For example, we need to understand hungry to appreciate a good meal, but coming into the light from darkness shows us how different the world can look from that we imagined. So, does letting go of one thing mean you lose the other, or does it mean we can better understand the qualities of different experiences, and perhaps the subtle gradations in between?

What happens if we let go of our identities, be they personal or professional? They may have been earned through countless years of study, or by being by beaten up in the school of hard knocks. Many of them are defined and placed upon us by ourselves or others like putting on a suit, or maybe a hat.

Society expects or demands us all to wear hats in most situations, as some kind of mental shorthand by which to identify it’s wearer. As any actor will display, or children will enjoy by playing dress up, our definition of ourselves can be changed, providing the opportunity to see and experience the world as a different place by changing our boundaries and expectations. If we change our title – be it doctor, dentist or lawyer – to drug pusher, jawbreaker or disingenuity practitioner, respectively, are we doing anything different? More importantly, does it feel different?

I would argue that it does. People’s reactions are usually very different if I were to describe myself as a mental health patient, versus a Consultant to the Royal College of
Psychiatry. Both are true, but one of them feels as if it builds fences or walls with people scurrying to be on a particular side. The other invites interest, and perhaps a sense of admiration. The preconceptions or reactions are very different though, according to context; the benefits or otherwise can only be experienced by varying our self-descriptors, and the values we place upon them in ourselves or others.

To close, I describe someone I know and value a great deal as being a ‘butterfly’: beautiful, inspirational and apparently without limits of flight or fancy. However, were I to try to catch or hold it in my hand, it would be damaged or destroyed. My challenge would be to let go of our title or self-descriptors for a little while, and allow the space and freedom to discover what new places we might be able to go, and whether people around us would actually like us to land on them.

**Something other than the ‘same old’**

Having been asked to revisit my hopefully gently provocative piece, I was asked to expand upon it, describing the circumstances leading to its creation, and perhaps reflections afterwards. Having proofread it for at least the millionth time, and naturally at the last minute, a few thoughts struck me. Being challenged to do something very different in terms of producing an article which was something other than the ‘same old’, I willingly picked up the gauntlet, as a result of which I discovered I was able to produce something I didn’t know I could do. At least it was unusual for me, and turns out to have been enlightening refreshing and undoubtedly beneficial in terms of personal and professional development.

There has been much written and reported recently about the dangers of disenagement in the Health and Social Care sector on every level between the individual and the institution they find themselves ‘boxed into’. The latter is an equestrian term, describing the situation whereby a horse gets stuck on the floor, and is unable to get up as a result of constraints which are as a result of their environment. The horse will die as a result. When this happens, someone else may spot it, and take action to bring about a remedy, for the benefit of all involved. It is not clear to me whether the horse may, through learned helplessness or the lack of ability to learn from experience thereby get stuck again in the same way. We can choose.

In turn, perhaps stepping outside the box ourselves, being ready to help others in the same predicament or even considering whether the environment is fit for purpose can lead quite some way towards avoiding the disasters we have all acquainted ourselves with via Francis, Winterbourne, Andrews, etc.

**Simon Mudie**

*Welsh Representative, DCP Service User and Carer Liaison Committee; South Wales Doctoral Programme in Clinical Psychology; HCPC Lay Visitor*

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**Division of Clinical Psychology Facebook page**

The DCP now has a Facebook page.

To get all the latest updates from the Division go to:

[www.facebook.com/divisionofclinicalpsychology](http://www.facebook.com/divisionofclinicalpsychology)
CMHT Network Annual Event

Developing Psychological Mindedness in MDTs (Part 2): Skills Development Workshop

Tuesday 14 October 2014, 9.30am–4.00pm
BPS London Office, 30 Tabernacle Street, London EC2A 4UE

This event is suitable both for attendees’ of last year’s CMHT network event, ‘Developing Psychological Mindedness in MDTs: Innovation and Evaluation’, and for those who did not attend but are interested in developing their skills in this area.

Event aims

- To model CBT, attachment and systemic approaches to developing psychological mindedness in complex mental health teams.
- To use interactive methods to enhance attendees’ skills and confidence in indirect work.
- To develop innovative ways of overcoming obstacles to enhancing psychological mindedness in MDTs.

Following the success of last year’s event, we are continuing the theme of how to develop psychological mindedness in multidisciplinary teams (MDTs). This will be an interactive workshop to increase attendees’ confidence and competence in indirect work. Katherine Berry will demonstrate her well-evidenced approach to working with teams from a cognitive behavioural and attachment perspective. Isabelle Ekdawi will explore her systemic approach to MDT work. Speakers will use interactive methods such as roleplay to model their skills. The afternoon will host small group workshops for attendees to enhance their own skills. There will be a focus on overcoming common barriers and ‘resistance’ in teams. The event will finish with a reflecting team exercise.

Speakers

The day is facilitated by the Networks Leads Anna Ruddle and Rosie Powling with speakers including...

Isabelle Ekdawi  Consultant Clinical Psychologist and Systemic Psychotherapist,
            South London and Maudsley NHS Trust

Katherine Berry  Clinical Psychologist, University of Manchester

Free event for members only

If you are a not a member of the Faculty of Psychosis and Complex Mental Health and wish to attend the event you will need to join the faculty first.

If you have any queries, please e-mail MemberNetworkServices@bps.org.uk, including ‘Mindedness in MDTs’ in the subject line.

This event is being financially supported by the DCP Faculty of Psychosis and Complex Mental Health, which has invested in it for the benefit of members.

To book, go to:
https://response.questback.com/britishpsychologicalsociety/cmhtpart2
Sharing the shadow

Gordon Milson

The title of this piece is inspired by the title of Professor Tom Burns’ book, Our Necessary Shadow: The nature and meaning of psychiatry. In this book Professor Burns, a psychiatrist, explains the title as such: Difficulties with well-being or mental illness are a consequence of humanity. Hence the difficulties, and psychiatry’s attempts to alleviate them, are a necessary shadow. If this is the case then clinical psychology can be seen as seeking to share the shadow with psychiatry. Another view is that clinical psychology operates in the shadow of psychiatry within modern mental health services. Psychiatry is the dominant model in mental health care and remains at the apex of the hierarchical structures of mental health services, at least in the majority of services. However, our core functions and aims are undeniably similar.

The origins, development and core role of both professions are complex; however, put simplistically, psychiatry can be seen as the study and practice of alleviating mental illness from a basis in medicine, whereas clinical psychology is the study and practice of the application of psychological thinking to people in distress. Even from my crude summary it quickly becomes evident that a certain amount of disagreement is predictable. It would seem that it is the nature of the training, and therefore the thinking, which leads to areas of debate and disagreement.

This disagreement in thinking around mental health is not a recent phenomenon. In her examination of Victorian approaches to people’s admittance to asylums, Sarah Wise (2013) documents evidence of the debates over the nature of ‘lunacy’ from as early as the eighteenth century, with the medical doctors, or alienists as they were titled at the time, declaring some people insane whilst others sought to demonstrate that an individual’s behaviour was contextual and understandable when the person was understood. Interestingly, these disagreements led to the formation of a group entitled the ‘Alleged Lunatics Friends Society’, whose founding member had experienced the system personally, and a subsequent member was the founder of The Lancet. Perhaps an early indication of experts by experience being vital in raising awareness of issues professionals can remind blind to?

I have worked for five years in an acute inpatient service for young people and have spent a considerable amount of that time in lengthy ward rounds with colleagues in nursing, psychiatry, occupational therapy and education, amongst other professions. There have been disagreements and debates, a fair proportion of which I’m culpable of initiating. The differences in training and approach are always evident; however, they are more frequently a strength rather than a hindrance.

This has only become possible, in my opinion (I’m mindful that I haven’t consulted my colleagues on this), because we have been in such unavoidably close proximity with one another and shared concerns about a large number of young people in various states of distress. Mutual respect allows for shared voices to be heard and differences of opinion to be considered. The anxiety caused by working with distressed children can cause avoidance amongst teams at times and professional dilemmas become more pronounced.

What I have found to be the most fruitful source of input from all professions is not the medication or therapy often described as the main tools of the respective professions, but the input that their training and mine allows us to contribute to the thinking and subsequent care planning of young people in dis-
tress. The key difference, I believe, lies in the primacy of causation that each discipline attributes to distress, which is undeniably a product of our training. Clinical applications of the continuum model of psychological functioning and distress have a significant role in devising care plans for young people with complex presentations. For example, formulating an understanding of people’s presenting difficulties in the context of their development and personality, highlighting factors which could be viewed as intrinsic and non-clinical aspects of the person rather than part of a disorder is essential when seeking to define success, recovery and defining when ‘treatment’ ought to stop. Likewise, when seeking to formulate risk, understanding the mechanisms which interact to maintain or exacerbate risk is an area which our training in psychology affords us essential and unique insights.

The training is more similar in length than often thought and publicised, psychiatry training (to consultant level) takes 13 years, whilst clinical psychology training (to newly qualified level) is on average nine years (three years undergraduate, an average of three years as an assistant or research assistant and then a three year doctoral degree). If the pathway to consultant grade clinical psychologist was to be used as a comparison, they would be almost identical, with the path to consultant level clinical psychologist taking a little longer.

The British Psychological Society careers website states that: ‘Clinical psychology aims to reduce psychological distress and to enhance the promotion of psychological well-being.’ This is a reasonable yet wide summation.

The Royal College of Psychiatrists leaflet on psychiatry careers states ‘Psychiatrists are medically qualified doctors who specialise in the care of patients with mental disorders.’ This is, in my opinion, equally reasonable and yet just as broad.

Those two statements show both our similarities: ‘...aims to reduce psychological distress...’ and ‘...the care of patients...’, but also our differences ‘...the promotion of psychological well-being...’ and ‘ medically qualified doctors... of patients with mental disorders’.

Whilst clinical psychology’s strength is having different grades and diverse areas of work, it is also perhaps an area of weakness, especially when seeking to establish roles in multidisciplinary teams. With respect to newly qualified clinical psychologists, the difference in role between them and consultant grade clinical psychologists is marked. We as a profession need to examine how we are considered by the decision makers in mental health commissioning. Is there a thorough understanding of the different roles and responsibilities of different grades of clinical psychologists?

Whilst there are many similarities between the professions, there is also a tension, which is at once historical in origin, but remains to this day.

In Civilization and Its Discontents, (1930/1961) Freud utilised the term, ‘the narcissism of minor differences’ to explain conflicts between parties appearing to be more similar to one another than different, he stated that: ‘It is precisely the minor differences in people who are otherwise alike that form the basis of feelings of hostility between them’. Whilst this appears an accurate reflection of the debates which occur between the professions, we also face challenges, both in terms of current standing and progression of our respective disciplines.

Despite the differences, it is possible that some more focused collaboration could be of benefit to both professions, and more importantly, those people that seek our assistance. The newly elected head of the World Psychiatric Association has stressed the need for psychiatry to take a more sociological and anthropological approach to assisting people and wishes to see training for psychiatrists altered as such. Furthermore, Sir Simon Wessely, President Elect of The Royal College of Psychiatry, has highlighted the need to repair the reputation of psychiatry and recruit into psychiatry. Whilst I’m not in a position to comment on the significance of these aims, they do differ to the challenges faced by clinical psychology. Clinical psychology, in my opinion, rather than repairing a reputation is still in the process of establishing its role and repu-
The role of therapy is firmly established and continues to grow within the NHS, with initiatives such as Increasing Access to Psychological Therapies (IAPT): however, the practice of clinical psychologists involves a great deal more than therapy, and its practitioners work in such diverse areas that its core role is yet to be established as of central importance to those with cognitive or emotional difficulties. We are placed in similar brackets on Agenda for Change pay scales to therapists and other mental health practitioners’ whilst our medical colleagues maintain distance from this. In my opinion, career progression in clinical psychology is at risk if the profession allies itself too closely to unimodal therapeutic provision, as increasingly this is undertaken by people on much shorter career paths and therefore lower wage demands. Our training prepares us for working most effectively with complexity so it should follow that psychological complexity is where we ought to focus our efforts. Whilst many in psychiatry strongly refute the suggestion that they are purely interested in medication, clinical psychology has for some time had to define it’s ‘added value’ as if they are little more than unimodal therapists, which is equally reductionist. Both are demeaning and unhelpful, but clinical psychology, more than psychiatry, has to justify its cost.

Notably, psychiatry is a profession which seems unique in that it has an ‘anti’ movement. There is no anti-haematologist or anti-paediatric orthopaedic surgery movement. It would be interesting to see how people reading this piece would respond to someone who identified themselves as an anti-clinical psychology. If you’re not sure, join Twitter, there are plenty of people who do so there. I for one would feel threatened, defensive and, although reflective, I would I believe feel some antagonism to my perceived attackers. Although the anti-psychiatry movement is often believed to reside solely in clinical psychology, this is not the case and even hardened activists would, I believe, state that their antagonism is focused more on biocentric models of well-being rather than the profession itself. The debates will continue and ought to, but the opening statements may need revisiting if discussion is to be productive. I for one do not identify myself as anti- any single profession or person; I’m more pro-choice, which by definition requires much more integrated leadership by people with experience of systems and difficulties themselves.

A most pertinent reflection which perhaps both professions ought to bear in mind when engaging in discussion regarding one another is that oft quoted sentence by Joan Riviere in one of her public lectures, regarding rivalry: ‘What we cannot tolerate in ourselves we are not likely to tolerate in others.’ A cautionary glance inwards is always worth considering before engaging in conflictual interactions with others.

Whilst differences remain, we both have our critics, which can be remarkably similar at times. As I’ve stated, psychiatry is viewed as having medication as its primary tool, much as clinical psychologists are essentially viewed as therapists. Both professions would wholeheartedly refute these stereotypes as simplistic and reductionist. So, what else do we both do? Well, therein lies the rub. The other tasks we do are also open to shared criticism. Diagnosis is criticised as being unscientific, but what is mooted as our alternative, psychological formulation, if it is claimed to be scientific, would also fall short, however inappropriate the comparison. The clinical decision making processes of both professions, whilst based in theory, are often influenced by our own preferences and presumptions. Theory is not necessarily scientific, many psychiatrists and clinical psychologists would cite the value of psychodynamic thinking to their work, either in direct or indirect interventions, but when it comes to rigorous ‘evidence’, psychodynamic theories remain precisely that. Both medicine and psychology are posited to be highly scientific; however, the application of these principles to people is far from the rigorous science
from which they develop. Trisha Greenhalgh (2011) has written eloquently of some of the problems of evidence-based medicine, many of which apply equally to clinical psychology. The scientific method is utilised by both professions, generating hypotheses, testing them and using the best knowledge available to make informed decisions regarding treatment. However, the information and therefore thinking used to make these decisions is different. Clinical judgement is a term often cited negatively in accordance with ‘making things up as you go’ by commentators seeking a wholly evidence-based service but, I believe, both psychiatrists and clinical psychologists often have to rely on this when seeking to assist individuals. Perhaps rather than an either/or discussion, more fruitful progress could be made attempting to give parity to both approaches and how both forms of thinking can work closer in order to better support people.

A colleague in psychiatry recently bemoaned the lack of time he has to see each person due to his caseload and invited me to shadow him so I could witness this. I would relish this opportunity, but for various reasons we have not been able to undertake this as yet. This did make me think, if I had 5 or 10 minutes with each person, what would I focus on, what would I ask? The return is as interesting; if he had around 45 minutes with the young person and also viewed the person in a therapy group – a different interpersonal context – which I am able to do, would he see the same person? I hope one day we can both trial this day-swap. The benefits of being trained to identify problems quickly is as useful as the ability to consider the whole person and the presenting problems in the context of that person. We both have strengths and weaknesses when it comes to service delivery.

Ultimately, we are all in the privileged position of offering a service to people and we must find more proactive ways of talking and working together in mutually respectful ways, if we are to maximise the benefit to those who really matter, those people who seek our support. What may be the most constructive way forward, if we are both indeed in the profession of assisting people in distress, is to both work together on how best to enhance the role played by people in distress in leading their care and having their views heard.

Outcomes for people experiencing distress are modest at best, if we are all honest. Some people find medication helpful, others find benefits in therapy. The most important question here is why some benefit and others don’t?

I believe the challenge facing both psychiatry and clinical psychology is to find more effective ways of talking together to improve services and to be open to one another’s knowledge and expertise. If outcomes for people who access mental health services are to be improved then the least that users of services can expect is that professionals can work effectively together to develop options and choices for them to access in order to maximise their own well-being.

This discussion, although it may make us both confront our own insecurities and concerns, is one which not only we, but also people seeking our assistance, requires us to have. The decisions we make and the ways we work together do and will continue to impact on those who seek our support. For that reason alone, closer working alliances with people who use and have experience of services ought to be integral to both professions’ progress.

The need to understand and assist people who experience psychological illness or distress casts a large shadow on humanity. There is room in it for all of us.

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When the opportunity to contribute to this special edition of Clinical Psychology Forum arose, through conversations on Twitter before Christmas, I don’t mind telling you that I jumped at the chance. I am far from a natural intellectual, and write far less prolifically than some of my fellow peers. However, the burgeoning relationship between psychology and psychiatry is one I feel zealously and passionately about. Whilst I appreciate the entire experience of training, as a trainee more inclined towards clinical practice than academia, the prospect of contributing to a special issue aimed at cultivating relations between multidisciplinary teams (MDT) was too good to miss. My subjective reflections, therefore, on the relationship between psychology and psychiatry are from the perspective of a second year trainee clinical psychologist.

I transferred to clinical psychology training from the forensic route after 11 years working in forensic settings, adult mental health and substance misuse, in addition to a smidgeon of research assistant experience. My interests lie principally in mental health services being accessible, proactive and of superb quality for vulnerable and often disenfranchised client groups. I wholeheartedly believe that a cohesive MDT and a greater level of solidarity between professionals at a systemic level plays an integral role in meeting these aims.

My experience of clinical psychology training
My particular training programme (Lancaster) is very much client and trainee centred. Whilst there is of course the compulsory attention given to the theoretical underpinnings of psychological models, and a strong research component, what I have valued most about my course is its emphasis on integrative formulation. The focus is on training to best meet client needs, and there is an ethos of trainees developing their own epistemology in order to mature into reflective and reflexive clinicians. Whilst this can be a challenging prospect, the ability to develop a more individual and organic stance in relation to psychological models, therapeutic relationships and the knowledge base is certainly advantageous when it comes to discussing the wider issues around psychology.

Inevitably, all programmes have their strengths and drawbacks, and whilst I consider the parley around conceptualisations of emotional distress to be of the upmost value, I have wondered from time to time if we need to balance this with a greater understanding of the diagnostic frameworks and medical model. For now at least, the majority of us work within those frameworks, regardless of our standpoint. As such, I sense that our knowledge of psychiatry, from a teaching perspective, is not as thorough as it could be. This perhaps proliferates the opportunity for unhelpful stereotypical narratives to permeate and fester. We have received teaching on the critical psychiatry movement, which was of course beneficial, though whilst I know opinions vary widely, personally, I would value a more rounded understanding of the profession.

As such, my knowledge around how psychiatry operates is based almost entirely on subjective previous experience, where a more traditional medical model and psychia-
try-led hierarchy endure, particularly within forensic and secure environments. My experience of psychiatry across clinical placements whilst on training has varied wildly. These experiences have without question been impactful and indispensable, not only in increasing my understanding of how mechanisms within mental health services interconnect and are impacted on by one another, but also in providing me with the opportunity to forge meaningful connections between disciplines and experience the resultant benefits personally, professionally, and most importantly, for clients.

Another hugely valuable resource in recent times in increasing understanding between disciplines has been social media, in particular Twitter. This special issue came about due to conversations between colleagues from both psychology and psychiatry who were united in their belief that Parity of Esteem needed highlighting more vigorously, which I believe is a hugely progressive and encouraging development. There are some remarkable individuals contributing to this seemingly never-ending flow of conversation, some of whom are involved in this special issue: @Huw tube, @bipolarblogger, @sectioned, @psychiatrysho, @gordonmilsom, @MasumaRahim and @SteWeatherhead are just a few among the assembled collective of psychologists, psychiatrists, service users and researchers, not to mention the many mental health agencies who contribute online. I have been struck by the breadth and extent of significant discussion consistently taking place in this virtual meeting space, and though there is sometimes the risk that debaters can adopt an inflexible and polarised position, I think that the overall benefits of this dialogue are extensive and far ranging.

Developing my own stance?
When I reflected on where my views about psychiatry have come from and how they have developed, I have to say I struggled to pinpoint a particular influence, or even identify how the various messages and narratives had infiltrated my thinking. Of course I’m aware of some of the unhelpful and narrow views that surround both psychiatrists and psychologists, but I have found the ‘divide’ to be some-thing of a false dichotomy. Personally, some of my most rewarding and developmentally useful learning experiences have been working in a genuinely collaborative way with MDTs, absolutely including psychiatry, and I think there is so much more overlap in our work than recent arguments might suggest.

I have worked with psychiatrists at all levels of qualification who sincerely support the necessity for psychological formulation, the limitations of medication, the current diagnostic system, and a more complete conceptualisation of mental distress. There are differences in our approaches and our paradigms of understanding, but I’m very much a believer that the more quality input a service user/patient can access, the better. As an advocate for attachment theory, when we work with so many people who have experienced fractured and disharmonious relationships in their lives, I think it’s massively important that we try to model a pro-social and unified way of working.

Having previously worried that I should have a ‘position’ on all things epistemology, and therefore, by proxy, psychiatry-related, I now recognise that constant flux in my thinking is not only natural, but advantageous. Not being completely fixed in a position allows for the processing of new information, and open-mindedness. The clients I’ve worked with have been an integral part of that, as has the teaching I have received. My position is shifting; I don’t take a particularly extreme stance; I am not concretely opposed to the concept of diagnosis, especially when it provides people with helpful ways of understanding their difficulties and means they can access services. Any perspective must, I believe, be led by the client.

However, ‘labelling’ of individuals with particular diagnoses that appear to suggest their ways of experiencing and relating to the world are inherently ‘disordered’ is unhelpful, but is happening less and less. People’s responses to difficult experiences invariably do make sense, and mental health is neither static nor ‘untreatable’. I have worked with people for whom medication is an integral and necessary part of their care plan, not least because it enables them to function at a level that means they can access therapy and the
rest of the support offered by an MDT. That said, I think individual psychological formulation is absolutely crucial; social and psychological factors are still wholly underestimated in a lot of settings. The current diagnostic framework is riddled with limitations and is still far too categorical.

Where do you see the future of your profession in relation to the others’?
Clinical psychology as a profession is growing exponentially. The ways in which clinical psychology and psychological ways of thinking can be incorporated across a wide range of settings, in addition to within traditional mental health services, is almost limitless, and I feel that there is still a trajectory of peak development for clinical psychology that perhaps psychiatry has already reached. Thus I feel the future is potentially great. We are living in austere times, however, and the need for us to ‘justify’ our roles by showcasing the full range of our competencies, including consultancy, teaching, training, research, and contributing to the social and political landscape has perhaps never been more necessary.

One of the areas in which I feel clinical psychology needs to develop more rapidly is in its public and media persona. There are great number of issues, particularly in an era where media influence is so dominant, where the Society and the Division could be making credible and useful statements, and contributing to public policy and discussion, not only around mental health but as part of a wider societal discourse. I’m not sure we are as active as we could be in this area, and I feel it’s wholly necessary if we want our profession to be treated with the same respect and eminence as psychiatry. The Parity of Esteem paper is a prime example of this. Parity of esteem for mental health services is wholeheartedly as crucial and part of clinical psychology’s value base as it is for psychiatry, and yet the majority of contributors to the paper were psychiatrists. Of course this reflects the dominance of psychiatry within mental health services and the medical model, but that will not change unless psychologists become more active in contributing to government level reports and publications. It would be wonderful to see, not only the public profile of clinical psychology gain some equality, but to increase the opportunities for psychologists and psychiatrists to come together on issues which affect our service users.

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Whose fault is it? A medical student's view on how the divide between psychiatry and psychology is perpetuated in undergraduate education

Lauren Evans

In geology, a fault is an interruption in a body of rock, where there has been significant displacement between the two sides. Due to friction and stress this fracture is rarely clean, and the results can be damaging to infrastructure and individuals. It seems a fitting, albeit strained, metaphor for the current fracture between psychiatry and psychology. It's also telling of how medical students are taught to understand the world, using the scientific method.

The archetypal medical student

Medical students, by selection, are proficient in and typically admirers of science. The focus on evidence-based medicine teaches medical students to be objective and balance risk in their practice. Whether extrapolating from first principles or learning by rote, medical students must strive to be faultless in the subtle pattern recognition of diagnosis and determining the safest management plan. Given medicine is also an art, this can lead to the patient (or service user) being their illness and not an individual. I have seen patients referred to as ‘the lady with a good murmur’ or ‘a patient with excellent signs’ and, in many situations, referred to by their bed number before or instead of their name. Although this is an example of teaching rather than direct patient care, as a result many medical students learn to mimic this style. Although many continue to have an excellent bedside manner, does their overall mindset change to viewing patients as an adjunct to a list of daily jobs? Communication skills are necessary for progression in medicine, but this is distinct from holistic care. The management should always respect the patient’s lifestyle when presenting treatment options. We are taught to include the acronym ‘ICE’ (ideas, concerns and expectations) in history taking, from our first year of studies. This is usually the first element of a consultation to get lost. I have yet to meet a doctor that doesn’t want the best for their patient, but when pressured by time and patient safety this doesn’t always factor in the management of said patient. It is true in psychiatry that consultation times do not allow for detailed exploration. With these constraints, how much should psychological components factor into the consultation?

Consensus of peers

Most opinions are influenced by peers, and this holds true in medicine. Before a medic has even begun their studies, higher cohorts are already recommending which lectures are vital and which can be ignored. This becomes a self-fulfilling prophecy, with psychology and sociology suffering from this informal introduction, resulting in poor attendance. These subjects are seen as ‘fluffier’ topics that can be extemporised during written exams (Gallagher et al., 2013). Although a holistic approach is taught as necessary in practising medicine, at an undergraduate level psychology is neglected across physical and mental health.

Medical students are encouraged to experience interprofessional collaboration at an early stage; this is usually with nurses, pharmacists and allied health professionals. However, medical students are still relatively segregated from these health students. There is an absolute partition of medicine
and psychology at an undergraduate level, except in an extracurricular capacity. Not all psychology students will wish to be clinical psychologists, but joint elements would be a valuable experience for those who do. It would certainly benefit medics.

**Views from teachers**
Perceptions of psychology are not only influenced by peers, but also teachers (whether they be clinical or academic). This can include psychiatrists and other mental health professionals. Many carry their own bias and preferences into teaching, which is true for all specialties, and these can be heavily influential. Much of the undergraduate course requires learning by rote – epidemiology, symptoms and management – which can leave little room for individual narratives. Due to the restricted syllabus for undergraduate medicine, identifying the common illness and red flags, broader knowledge and awareness of psychological aspects can be hampered.

**Clinical observations**
Although placements in psychiatry are a core element of an undergraduate curriculum, in varying degrees depending on medical school, exposure to psychiatry (within the mental health setting) is limited. This means that exposure to psychological components of the specialty are further limited. My personal experience was a newly introduced workshop in cognitive behavioural therapy that explored the principles, but gave little clinical context. It was also poorly received due to the pre-existing prejudice amongst many students. Many perceive psychological treatments as another prescription with little understanding of what it entails. In the broader experience of psychiatry, with psychological services being oversubscribed, psychiatrists and other mental health professionals can find themselves managing a less than desirable situation. Supporting service users without psychological input is an approach that permeates to the next generation.

Most of my participation in clinical psychology has been through an elective placement, which comprised of a functional assessment, supervision for case formulation, and reflective practice. This was still a minority of my placement, but I took encouragement from how well integrated the team I shadowed was. The team had their own wellness recovery action plan, and were reflective on their relationships with each other. This promoted open and non-judgemental communication, and demonstrated how well psychiatrists and psychologists could work together in a team.

**Ethics**
In practice, giving medical students exposure of psychological sessions presents huge problems. Psychological therapy is a deeply personal experience, and having just one medical student could be an intrusive experience. With so many medical students on each placement, would it be possible to accommodate those numbers and should they take precedence over psychology students? A discussion needs to be had about how medical students can see the process and clinical relevance of psychological therapy without presenting barriers to the service user.

**Media**
It is not just course experience that influences a medical student’s perspective, but the same influences as the general public. Responsible reporting and representations in popular culture shape health literacy and attitudes. A prime example for mental health is the public’s view of electroconvulsive therapy, mirrored by many health care professionals, but also psychological therapy. For many their picture of psychological therapy is a caricature of the Freudian couch.

**Service users**
From my conversations, there is an overwhelming desire from service users to have greater access to psychological therapies. This is undoubtedly an issue, and there is a lot of anger about waiting lists and thresholds for accessing these therapies. A second theme I’ve noticed, relates to the concept of ‘pill shaming’. This is the idea that those who take psychotropic drugs for their mental health problems are stigmatised, with the belief that they are unnecessarily medicating themselves.
When viewpoints are polarised along these themes, it causes a rift through collaborative care. Interventions are used against each other, rather than in conjunction. Ultimately, this harms the service user. A service user’s choice should be respected, but must be informed. This requires a joint care approach, where false public and professional judgements are addressed.

Conclusion
It should be emphasised that not all students, nor the professionals who teach them, perpetuate this disparity. However, identifying the sources of this divide can allow it to be addressed. It is hoped that these students will carry this into their clinical practice, ultimately providing best care for the service user. These students have often had good mentors, so we must focus on that.

How do we achieve this tectonic shift, to introduce parity of esteem at an undergraduate level? Early positive exposure to both psychiatry and psychology is valuable to professional development; a work experience at 16 not only introduced me to psychiatry but demonstrated to me that an individual’s health is far more than pathology. Seeing the personal experience of mental illness allowed my introduction to medicine to be a more holistic one. Collaboration between medical and psychology students would be beneficial for addressing stereotypes. Our Psychiatry Society, wherever possible, seeks to include psychology students (amongst others). This provides a breadth to discussions and a valuable early alliance. Within the course, a variety of teaching to illustrate different styles and viewpoints facilitate professional development. Multidisciplinary ward rounds with both psychiatrists and psychologists working successfully together set an example to be emulated. Personally, I find cross-profession discussions the most valuable experience in addressing this divide. This leads to collaboration and best patient care. Opinions of respective professions are not set in stone, and at every level of training candid and respectful discussions must be had about where the differences exist and how they can be resolved. Identified errors should be used to progress relations, not to blame.

In the words of Ralf Waldo Emerson: ‘We learn geology the morning after the earthquake.’

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During the build up to and since the publication of the fifth edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 2013), the issue of diagnosis has been increasingly under the spotlight. It has been the source of much discussion and tension between the fields of psychiatry and psychology (e.g. Bracken et al., 2012; Division of Clinical Psychology, 2013), where there are mixed opinions, both within and across these professions.

In our own clinical setting (early intervention in psychosis), this discord about the validity and use of diagnosis is very much alive. There are different positions and approaches adopted by clinicians and there are different ways diagnosis can be received and used by service users. It is this array of perspectives on and responses to diagnosis that has meant we have been compelled to think about the issue in the context of our clinical practice and the academic literature. When the opportunity arose (via an advertisement @steweatherhead made on Twitter) to look at this further as part of delivering a teaching session for third year trainee clinical psychologists, we agreed this felt like a helpful and unique platform to explore and debate diagnosis more fully.

The teaching was a full day’s session for the Lancaster University Clinical Psychology Training Programme. Our aim was to look at the purpose, use, critiques of and alternatives to diagnosis. We wanted to encompass the views of service users, psychology and psychiatry across theoretical and clinical perspectives. We felt it was important to open a dialogue about the use of diagnosis to allow people to explore and reflect on the tensions that exist.

Moreover, it was an opportunity for us to work together, to consolidate our own thinking and convey in a ‘real’ way how the conflicts around diagnosis can be enacted between us as professionals and what this means for our work.

**Development and delivery of the session**

In constructing the content for the day, it became a real chance for us to share with each other our own personal and professional stance on diagnosis in a more explicit and transparent way. Working within a busy service, there is often little time to reflect on how different clinicians view diagnosis, to determine what drives their decision making or to consider how they view mental health difficulties within their own personal ways of conceptualising distress. Having these discussions highlighted how our position on diagnosis was influenced by a number of factors (e.g. the duties of a psychiatrist, the historical context of our professions, the issue of science and the evidence base). Even though we had a shared belief in a ‘bio-psycho-social’ framework for mental health difficulties, there was a fundamental difference in our approaches; as a psychiatrist leaning towards a biological and medical model and as a psychologist leaning towards an emphasis on life experiences and social factors. It is through these lenses that our work is approached; the language that is used, the interventions we adopt and the messages we convey to service users about mental health. Our teaching sought to reflect the view through these lenses, the limitations of such approaches and how our positions fit with the academic, service user and wider socio-political debates on diagnosis (e.g. examining the validity and reli-
ability of diagnosis, service user experiences of validation and stigma through diagnosis as well as how diagnosis maintains certain discourses within society).

Our discussions brought to the fore how much we take for granted about our respective professions, both in relation to our training and the roles we adopt. We noticed there are few opportunities to learn about ‘what we do’, and much of this can be assumed. This allowed us to generate questions that we felt might be important to address within the teaching (e.g. what do clinical psychologists know about the purpose and process of diagnosis from a psychiatrist’s perspective?). We considered the wider context of our professions and what this may mean for clinicians and their use of diagnosis (e.g. the implications of professional guidelines, societal expectations and systemic structures). Furthermore, we reflected on differences not only in the way that our training is structured, but also in the way it is delivered, and the bearing this has on our development as practitioners (e.g. the style of teaching on the clinical psychology programme can often be more exploratory and discursive, compared to a more didactic style within medical training).

Ultimately, we wanted to convey the complexity of the issues surrounding diagnosis for us as clinicians. Invariably, we are drawn into conflicting positions within our work about the use and experience of diagnosis (e.g. where diagnosis is sought or rejected or where it is seen as stigmatising or validating). We wanted to encourage trainees to consider the dilemmas faced in routine practice (e.g. working with a service user who rejects their diagnosis, but wants you to complete a benefit form where you must state a diagnosis/prognosis), as it is these scenarios that can force us to re-evaluate or shift our position.

**Reflections and learning points**

‘…the teaching on diagnosis was brilliant – really unique, interesting and informative. It felt really safe to explore things – the psychiatrist was open and felt able to share their point of view and the psychologist held everything together very well. We had some really interesting discussions about polarisation, and integration of formulation and diagnosis.’ (Roxanna, Third Year Trainee Clinical Psychologist)

**RM (consultant psychiatrist)**

When the opportunity to take part in this teaching session was first discussed, I remember having some initial misgivings, but then starting to feel quite enthused about the title, and the chance to think about this thorny topic in more detail.

Diagnosis sits at the heart of medical practice. In psychiatry, trainees learn about formulation, and the dominant framework during training is the ‘bio-psycho-social’ model; however, diagnoses remain critical in terms of making sense of people’s experiences, communicating with others (especially general practitioners and non-mental health professionals) and responding to the expectations of those who consult with us.

I have been fortunate to be able to work closely with a psychologist colleague in our service, and this has enabled me to think more critically about my own position, but also the position of psychiatry in general. Delivering some teaching in this area was a chance to open a dialogue with trainees from another discipline, and provide a little more context for understanding psychiatric practice.

Although I was somewhat apprehensive about being the only psychiatrist in the room, the trainees were welcoming, and I felt we were able to work together collaboratively. I formed the view that training in clinical psychology is more different from psychiatric training than I had imagined; it was fascinating to be able to see this from an active perspective as a teacher, rather than as a passive onlooker. I had a strong sense of critical and challenging faculties being developed; whilst this allows practitioners to develop a very personal approach to their work, I wondered how this sits with practitioners from other disciplines with very different approaches. I also realised how much I take for granted regarding others’ knowledge about my training and the experience of practising as a doctor.
My experience of multiprofessional training at university was of awkward sessions with little opportunity for real dialogue or for the development of a real understanding of the perspective of others. This session felt more exploratory, and more productive. It gave me hope that, given the right setting and planning, multiprofessional training could become more widely available and more widely appreciated.

If I were to deliver this training again in future, I would aim to spend more time considering how the service user perspective might better be represented in the day. However, I think the benefits of enabling a dialogue between psychologists and psychiatrists have a value of their own, and shouldn’t be overlooked.

Psychologists and psychiatrists share a critical interest in the care of people presenting with mental distress, whether conceptualised as a mental disorder, or in terms of a highly individualised formulation. They also share high levels of academic training, and key roles in the delivery of mental health care. My personal view, reinforced by the positive experience of delivering this training, is that care is best delivered from a position of mutual respect and support rather than enactments of a polarised ‘them and us’.

RT (clinical psychologist)
This was a unique opportunity to work with psychiatry in a different way and to present to trainees what we believe are some of the pertinent issues around diagnosis. It helped me to consolidate my own position on diagnosis; to appreciate more fully that while I place an emphasis on the importance of relationships and the environment in the development of mental health difficulties (and thus lean towards the use of formulation), many service-users seek and benefit from the use of diagnosis – refuting this can be experienced as dismissive and invalidating. Furthermore, this was an opportunity (not just for trainees!) to ask questions of psychiatry, to learn from a different perspective (e.g. when listening to how a psychiatrist understands their own use of diagnosis) and to question my thinking and ways of working.

Inevitably, there was an anxiety in delivering this type of teaching, as it brings to the fore, in a public way, the very tensions that exist in our day-to-day work. I was aware that the teaching session had the potential to enact both personal relationships with diagnosis and relationships between psychology, psychiatry and service users. For example, where diagnosis is experienced as critical, controlling and invalidating one can be left feeling criticised, controlled and invalidated. This is a dynamic that can exist between psychiatrists and psychologists as well as between professionals and service users (e.g. when there are differences of opinion and approach). Within the teaching session, there were opportunities for such roles to be enacted (e.g. if the trainee group disagreed with the opinion of the psychiatrist). It is with this in mind that we sought to create a dynamic that allowed for us to stay with differences in opinion, so that they could be explored. Arguably, the purpose of taking an interprofessional approach to teaching is to encourage the development of more helpful relationships that foster respect, validation and containment. The parallel here being that if diagnosis is experienced in this way, then it can be seen as helpful in its use (e.g. Dinos et al., 2004).

The polarised positions that some individuals have taken towards diagnosis (both within and across the professions), although helpful at times (e.g. as they can raise important questions and force us to challenge our perspective), have also served to close down conversations and widen the gap between interprofessional working. In our own practice, we’ve tried to cultivate a helpful relationship through creating dialogue; the opportunity to teach together, to draw from knowledge across our professions and to be open to the tensions that arise have all been part of the process.

Inevitably, the subject of diagnosis is one which is emotive and contentious. At times,
our own discussions reflected this; it is hard to remain dispassionate and critical given the many influences on our understanding and use of diagnosis. Perhaps our most helpful anchor has been the voice of service users. We were continually reminded of the multiplicity of views that service users have expressed about diagnosis, and it is this that we hoped to reflect in the teaching, and to hold on to as we have continued with our work.

Working together
There is an emphasis in mental health teams for interprofessional collaboration. Teaching together, thinking together and learning together are all ways in which we can develop our empathy and respect for the multitude of perspectives that come with multi-disciplinary working. As Chambers, MacDonald and Mikes-Liu (2013) remind us, we must hold in mind that our clients are bigger than our paradigms. While there is no easy resolution to the difficulties surrounding the issue of diagnosis, we hope that our teaching is a reflection of what may be helpful as we continue to grapple with finding ways of making sense of people’s experiences. We must work together, with an awareness that we are all operating with limited knowledge, and retain a willingness to open a dialogue across professions and with service users.

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References

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<tr>
<th>BRISTOL</th>
<th>PART 1 DATES</th>
<th>LONDON</th>
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</thead>
<tbody>
<tr>
<td>22-23 January 2015</td>
<td>25-26 September 2014</td>
<td>16-17 October 2014</td>
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<tr>
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<th>EDINBURGH</th>
<th>LONDON</th>
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<tr>
<td>27 November 2015</td>
<td>16 October 2015</td>
<td>4 March 2015</td>
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<td>1 July 2015</td>
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Interview with a service user, a psychologist and a psychiatrist

Charlotte Walker, Ruth Ann Harpur-Lewis & Alex Langford

Mental health service user, activist and award-winning mental health blogger Charlotte Walker talks to psychologist Ruth Ann Harpur-Lewis and psychiatrist Alex Langford.

1. Describe your job in 140 characters or fewer.
Psychologist: Applying psychology to clinical issues from the people we work with to the staff teams and the organisation.
Psychiatrist: Doctor seeing patients with mental illness. The causes vary – from organic disease to stress reaction, and so do the treatments – from mindfulness to medication.
Charlotte: I’m really happy to see patients (and I’ll accept the term, since ‘service users’ would have required an additional five characters) at the very heart of what psychiatry is about. I’m not sure I’m any the wiser about what a psychologist does!

2. What is the biggest misconception about your profession?
Psychologist: There are lots! One of the biggest is that my main role is to offer therapy. I do offer therapy but I also do a lot of work with my colleagues in an acute adult mental health in-patient unit helping them to make sense of patients’ difficulties and how best to work with them. I also spend a lot of time helping staff to think about their interpersonal style and how to communicate effectively with each other and with the patients we find most challenging.
Psychiatrist: There are a few, like the fact that some people think we only view patients as soulless diagnostic labels. But one of the misconceptions that worries me the most is that a proportion of the public, and even medical students, don’t even know we’re doctors. They mistake us for psychologists, and even for psychoanalysts. Anyway, for the sake of mental health, we need to publicise ourselves better.
Charlotte: I was aware that psychologists worked in in-patient settings but was interested to hear of the staff development aspect to the role. Service users often have a sense of being viewed as ‘difficult’ or ‘manipulative’ by staff, so I am pleased to learn there are mechanisms for staff to examine their own responses to those they care for. I agree that there’s a lack of distinction between professions in the public mind; worryingly, services themselves sometimes fail to make these distinctions clear to the people who use them. I have more than once heard someone speak of ‘seeing their psychiatrist’ when it is clear from the context they are in fact seeing a psychologist or an IAPT practitioner.

3. How important is diagnosis in alleviating people’s emotional pain?
Psychologist: I think one of the biggest advantages of diagnostic categories is that they allow us to develop and evaluate specific ways of working with specific problems. The disorder specific cognitive behavioural therapy (CBT) models are extremely helpful in directing therapy (for example, including reliving-based interventions for treating post-traumatic stress disorder (PTSD), which we now know has a big impact on the effectiveness of CBT for PTSD). We can make the case for better service provision (e.g. by demonstrating the clinical cost-effectiveness of dialectical behaviour therapy services for people who meet diagnostic criteria for personality disorder). Categorisation is an important part of developing good evidence-based interventions for specific difficulties and ensuring these are offered to people who need them.

That is not to say that diagnosis is the be all and end all. Of course as a psychologist I want to ensure that we understand an array of factors involved in someone’s distress and adopt a holistic
and individualised approach. I don’t think diagnosis in any way prevents this. Indeed, the two can work together very productively. In the case of PTSD, I would want to understand that individual’s trauma, what it meant to them in their lives, for their relationships and their wider social context and the difficulties they are experiencing. I would also want to understand that in the context of what PTSD is and what we know about PTSD from the evidence base.

Psychiatrist: Categorising people as well as seeing them as individuals allows us to understand them better and give them advice about what to expect. It allows us to research conditions and come up with treatments that work – like dialectical behaviour therapy for borderline personality disorder. Our labels aren’t perfect of course – some people fall between the boxes we have, just like countless patients do in physical medicine – but we can certainly tell the difference between big groups like phobias, bipolar disorder and obsessive compulsive disorder. To stop using diagnosis because the boxes aren’t perfect and some people use labels in a meaning-stifling way would be a huge backward step. It would lead us back to views like ‘depression is just unhappiness’, which is a hideous thought. Our patients deserve diagnoses.

Charlotte: It appears to me that some people who ‘fall between the boxes’ find this quite liberating. For others, feeling that not even experts in the field know ‘what is wrong with them’ can add to distress, as can frequent changes of diagnosis. On balance, I’m in favour of diagnostic labels, largely for the reasons Ruth Ann and Alex cite: finding the label which appears to closely match an individual’s pattern of distress allows clinicians to tailor treatment based on best available evidence.

However, one of the biggest concerns I hear expressed is about the rigid application of diagnosis-linked guidelines, particularly with regard to talking therapies. There is a sense of evidence-based practice having become a rather robotic, ‘You have Condition A, therefore you are only suitable for/entitled to therapy X’ approach. Offering service users a ‘choice’ of one particular form of therapy or no therapy at all fails to involve individuals in decisions about what’s needed for their recovery.

4. Do the drugs work?

Psychologist: It depends on what you mean by work. Do they alleviate distress? Yes, sometimes they do. Sometimes psychological therapies are impossible before someone has had medication to lift their mood or calm down the extremes of an acute manic or psychotic episode.

Do they also have horrible side effects? In some (indeed, many) cases, yes. Do the pros outweigh the cons? Some people who are prescribed drugs say yes and some say no. They can certainly be helpful.

I guess for me the issue is that not enough people get offered psychological therapies, support with social issues or vocational opportunities, amongst other things. These are vital in peoples’ recovery and the lack of them means that our relative emphasis is on psychiatric medications as they are readily available. I think it’s more important to fight our corner for increased access to therapies, social supports, vocational opportunities, etc. than to fight against drugs.

Psychiatrist: There is good evidence that the drugs work – in fact, psychiatric drugs are some of the most effective in the whole of medicine. But we have to remember what ‘work’ means. It means dampening down awful feelings, providing a stable mental place for recovery to start – which can be all some people need. But drugs don’t magically remove bad memories, or find someone a meaning or a purpose; that still has to be done using other methods, like talking therapy, psycho-education and social support. Unfortunately, because of funding restraints it can look like drugs are all we offer sometimes, but every psychiatrist I know recognises the value of social and psychological support.

Charlotte: There have been times in my life when I have simply wanted to be given a magic drug and immediately restored to normal function. Partly, this was due to media stories about the ‘controllability’ of mental health conditions and talk of ‘chemical imbalances’ creating unrealistic expectations of what drugs can achieve. At the other end of the spectrum the narrative of psychodynamic drugs as ‘happy pills’ – with the distinct implication that their use is somehow weak or shameful – rumbles on.

I think what most people want from their clinician, whether at a first contact with a GP or as part of ongoing secondary care, is to be steers between these two absolutes. Relevant drugs need
to be on the table as part of informed discussion and choice, but many people will want alternatives, particularly talking therapies, to be readily available. All too often, a decision not to take drugs, especially among people with complex needs, results in a response of, ‘Well, what do you expect us to do for you if you won’t take medication?’, with vocational or social support also being withheld because they are ‘not motivated to engage in treatment’. Meanwhile, many people at the mild to moderate end of the spectrum might like to try antidepressants but are sent home by their GP with bibliotherapy or the suggestion they exercise more. We need more flexibility and individuality in prescribing, just as we do in referral for talking therapies.

5. Can mental distress be meaningful?

Psychologist: Of course! However, I don’t think overanalysing everything in huge detail is always helpful. Ruminating on past experiences and trying to figure out what they mean can be just as problematic as denying that they have any meaning whatsoever. I try to find the middle ground.

More importantly, people have all kinds of experiences and stories about themselves, so I’m not just interested in the mental health difficulties that people I work with have experienced; I’m interested in their relationships, their culture, their resilience, their values and pretty much everything that makes them who they are. I think our entire approach to mental health needs to pay attention to these things as well if we are really going to help people with their recovery and to live the lives as they see as most worth living.

Psychiatrist: It would be pretty difficult not to find it meaningful. It’s a real shame that people seem to think psychiatrists only see a brain disease when a patient walks into the room – in reality, most of us went into the specialty because we love talking to people and finding out their stories. Just because we see people as having illnesses doesn’t mean those illnesses don’t express themselves as part of a unique person with a profound history. It’s perfectly possible to categorise something and still see the individuality in it – Picasso was a cubist, but calling him such doesn’t make his paintings any less meaningful.

Charlotte: If we are to provide treatment which is meaningful to the client, it would seem fairly obvious that we need first to establish the meaning of their distress, including its long- and short-term causes and effects. Sadly, the approach outlined by Alex is not one I have encountered for the majority of my time in the system, nor is it one I hear regularly described by service users. Too many encounters still take a very mechanistic view of emotional pain, with the goal being to control that pain via medication without delving into its causes. Not everybody wants or needs their pain dampened; for some it’s a very valid reflection of their past or present circumstances. Talking therapies as are currently used can create the same problem, with many people referred for cognitive behavioural therapy complaining that it too only really tackles surface distress/symptoms. Working with the whole person as Ruth Ann describes sounds ideal, but here we are again up against the resource issue. A truly flexible, person-centred approach to therapy simply isn’t a reality in services so tightly bound by cost that treatment is parcelled out in packages of four, eight or sixteen weeks.

6. What do you find most frustrating about the medical model?

Psychologist: Sometimes I find the focus on diagnosis and medication extremely frustrating. I work in an acute in-patient unit. If someone with a diagnosis of schizophrenia or bipolar has a relapse one of the first questions he or she will be asked is, ‘Did you stop taking your medication?’ If the answer is yes, then this is deemed to be the reason for relapse. Of course, the person may not have been taking their medication for over a year before they relapse in which case the question is why now? Or even if stopping medication directly precipitated a rapid deterioration in their mental health which necessitated an acute in-patient admission, what factors contributed to them deciding to stop? There is always more to the story. However, I don’t think this is implicit in the medical model and is more about how the model is being used. Which then begs the question: Why is the medical model being used and abused in this way? I think the increasing time and resource pressures we are under are key factors in making it harder to think more broadly about the people we work with.
The answer isn’t decreasing the medical model or use of medication or role of psychiatrists. It is increasing and investing properly in everything else and giving people the time and resources to engage holistically with people. Psychiatrists have enormous caseloads and in-patient staff are often struggling to manage an extremely busy and sometimes very chaotic environment. As a psychologist, I am privileged to have a lot of protected time for the people I work with. Having a full hour to meet with people is a luxury that few of our colleagues are afforded.

I don’t believe that my psychiatry colleagues would disagree with this. Indeed, they are my allies, not my enemies, and I find crude characterisations of ‘medical versus psychological’ or ‘diagnosis versus formulation’ and any other ‘us versus them’ to be far more problematic and frustrating than anything about the medical model.

Psychiatrist: We’re taught a lot about the psychological model as psychiatrists and it complements the medical model very well in practice, so in my view the ‘psychiatry-psychology divide’ is largely a counterproductive work of fiction. But extremists who claim either model to be the ultimate truth can make me roll my eyes. Like radical psychiatrists who flaunt brain scans as an explanation for mental illness, psychologists who claim to be able to make illnesses ‘disappear’ by constructing them using cognitive models look a bit naive and generally aren’t helpful. One model by itself is just a description of an illness – only by combining all our models will we ever get an explanation. The brain and its product, the conscious mind, are the same thing described at different levels.

Also, the psychological model doesn’t tend to use value-laden words like ‘ill’. For some people this is a liberation, but for others who really need those terms, it can fall short of the conceptualisation they need from society to help them recover.

Charlotte: As a service user, I too find media tales of a ‘split’ or even a ‘fight’ between psychology and psychiatry inaccurate and unhelpful – the last thing an NHS patient in any specialty needs is to be told that there is infighting in their care team. To an extent, I share both Alex and Ruth Ann’s concerns about each other’s fields. I have already made it clear that although I value the medical model when it is applied well, the stories I hear on a daily basis are of doctors whose comfort zone lies only in prescribing. Channel 4’s series Bedlam may have opened the public’s eyes to the diversity and complexity of mental health work, but it also reinforced the same old story: patient stops meds; patient becomes unwell; patient is brought into in-patient care; patient is stabilised on meds – happy ending. At the opposite extreme, I too feel frustration when words like ‘ill’ or ‘unwell’ are shunned; this can feed into a dangerous attitude which sees even severe and enduring mental illness as just a part of human experience and becomes a topic upon which anyone and everyone feels entitled to comment since they are, after all, human too. This is folly and undermines the lived experience of someone who knows they are dealing with something much more difficult than most people’s experience.

7. If you had the power to change one thing about NHS mental health services, what would it be?

Psychologist: I would increase investment across the board and take the Recovery model seriously. That means providing really good community services, including places for people to go during the day, access to community resources and supporting people with education, training and employment. It means properly investing in staff, training them to a high standard and ensuring they get good quality professional development and ongoing clinical supervision. It would mean that a two year wait for psychological therapy would be considered as much of a scandal as a long wait for medical treatment.

Without this investment, staff feel they are fighting just to keep their heads above the water and will continue to focus on risk management, troubleshooting and what absolutely cannot wait, and ignoring anything else. This is key in preventing mental health services from engaging creatively and compassionately with people towards recovery.

Psychiatrist: If it has to be one thing, everything ends up being related to money. If we were funded in line with the morbidity burden of mental illness (instead of getting barely half of what we should), we could afford more staff, who could be trained to a higher standard and spend more time with patients, free to get to know them instead of being overwhelmed by a massive caseload.
and risk-orientated paperwork. Our dilapidated wards could be made more therapeutic. A lot of our perceived negatives (being medication-centric, dismissive and impersonal) stem from not having enough time or money to do things the way we genuinely want to. We’re so used to surviving on a pittance that we don’t complain enough. No other specialty would put up with this.

Charlotte: I am distinctly wary of Ministerial promises of ‘parity of esteem’. This feels like a policy phrase whose meaning in practice remains obscure, and fudges the funding issue. What I sense from Ruth Ann and Alex, as well as from people with lived experience, is that all parts of the mental health community want to be taken as seriously as any other specialty. Professionals and service users alike are tired of being told year after year that mental health is the ‘Cinderella service’ of the NHS without positive action being taken to address this, and yes, fundamentally, this means injecting more money into the system. I want mental health to be properly resourced so that it can appropriately, flexibly and holistically support people in the community, with continuity of care and continuity of practitioner making in-patient care a truly exceptional course of action.

8. What do you most value about the other profession’s perspective?

Psychologist: What I most admire about psychiatry is that before psychiatry those we would now think of as mentally ill where consigned to the margins of society, seen as insane, undesirable and even sub-human characters locked away from the rest of the world. Psychiatry introduced systematic ways of thinking and understanding difficulties that appeared incomprehensible. Instead of seeing people with such difficulties as freaks, psychiatry saw them as people with illnesses, deserving of and needing medical care. As such, psychiatry has devised largely humane ways of understanding and treating people who society might otherwise treat appallingly and enables many people who might otherwise be plagued with extreme mood states or psychotic experiences to live fulfilling and meaningful lives. I think our mental health systems are far from what they could or should be and I think we over-emphasise treatment with medication and neglect vital social and psychological issues the people we work with face. I think we have a very long way to go. However, the history of psychiatry is one which has seen the people we work with as first and foremost people who deserve attention, care and the same systemic understanding and treatment provided by the rest of medicine. That is a legacy to be proud of and to build on to attain better, more holistic and compassionate ways of supporting people.

Psychiatrist: I admire the patient-centred ethos that psychologists operate with. Over the years, doctors have improved a lot in their communication skills, but we still sometimes only communicate as a means of eliciting someone’s mental state. Though doctors in every specialty are getting better at collaborating with and deferring to patients, psychologists have already got that down. We shouldn’t be afraid of that way of working – we can still be psychiatrists in that model.

Charlotte: I value anyone’s choice to work in the NHS, and particularly in mental health, given the challenges already explored and that the depth and breadth of training required for both professions is huge. Speaking only from my own experiences, I have found psychologists tend to make better ‘professional friends’ who feel firmly on my side and fully validate my perspective and experiences. Only in very recent years have I found anything approaching this level of support from psychiatry, and sadly I continue to hear horror stories of dehumanising and insensitive practice on a daily basis. When psychiatry works well – as it does for me at present – a consultant is exactly that: somebody with vast theoretical knowledge accompanied by immense clinical experience who is able to share those resources with service users in a way that is comprehensible, practical and helps them to make decisions. I believe, as Alex says, that psychiatry needs to collaborate more with patients in this way so that doctors are deciding with service users, not deciding for.

Interviewees: Charlotte Walker (@BipolarBlogger), Service user, activist and award-winning mental health blogger (www.purplepersuasion.wordpress.com); BipolarBlogger2011@gmail.com; Ruth Ann Harpur-Lewis (@BelieveCBT), Senior Clinical Psychologist, South London and Maudsley NHS Foundation Trust & Dr Alex Langford (@psychiatrySHO), CT2 in Liaison Neuropsychiatry, King’s College Hospital; alexander.langford@slam.nhs.uk
THE PROFESSION of psychiatry is facing a crisis; one that originates from within.

It is reflected by the pharmaceutical industry’s disinvestment from new drug development in psychiatry. The prominent psychopharmacologist Christian Fibiger recently wrote ‘...a massive experiment has failed: despite decades of research and billions of dollars invested, not a single mechanistically novel drug has reached the psychiatric market in more than 30 years (Fibiger, 2012, p.6). Coincidentally, Peter Tyrer, then editor of the British Journal of Psychiatry, wrote of ‘...the end of the psychopharmacological revolution...’ (Tyrer, 2012, p.168). This is evidence of a crisis at the scientific heart of psychiatry, related in part to its failure to validate a single psychiatric diagnosis, and to develop effective drug or physical treatments based in scientific knowledge.

In this paper I want to examine how some within the profession have interpreted this crisis through recent special articles published in the British Journal of Psychiatry. Their responses are probably not typical of the majority of psychiatrists, but two of these papers represent a powerful and influential body of academic thought within the profession. They promise future insights into psychosis through neuroscience and molecular genetics; a promise they use to justify continuing medical dominance in mental health practice. The promise upon which this justification is based is hollow, given the repeated failure of biological science to validate psychiatric diagnoses. There are good reasons to believe that, in future, neuroscience and molecular genetics will fare no better.

The crisis as a threat to medical authority

Craddock et al. (2008) suggest that psychiatry faces a crisis of authority brought about by a ‘downgrading’ of core elements of medical care in psychiatry, particularly the belief that the profession offers specific treatments based in diagnosis. They identify a number of factors important in understanding how this happened. These include a broadening of the concept of ‘mental illness’, which undermines the priority of serious mental illness for those responsible for commissioning mental health services; scepticism within the profession towards the value of scientific studies of mental illness; and interprofessional rivalries between psychiatrists and other professional groups in mental health. They claim that patients have a right to expect more than ‘non-specific psychosocial support’. At some future point, advances in molecular genetics and neuroscience will yield new targeted biological treatments for psychosis (Craddock et al., 2008; Bullmore et al., 2009).

Changing interprofessional relationships between psychiatrists and other mental health professionals are a particular threat. For example, Craddock et al. (2008) see New Ways of Working, the programme of work undertaken jointly by the Royal College of Psychiatrists and the Department of Health (Department of Health, 2005) as an attack on medical leadership in multidisciplinary teamwork. The traditional relationship between general practitioner (GP) and hospital specialist was based historically in the right of the GP to refer patients to hospital specialists of her or his choice, who then assumed responsibility for the patient’s care. The distributed model of care supported by New Ways of Work-
ing means that not all people referred to an ‘anonymous team’ for specialist mental health care are assessed by a consultant psychiatrist.

The second paper (Bullmore et al., 2009) shares many concerns with Craddock et al., but focuses on the central role of neuroscience in psychiatry. This is a call for psychiatry as a progressive medical specialty, ‘...fully engaged with the science of the brain.’ (Bullmore et al., 2009, p.293). They assert that neuroscience is central to the use of drugs in psychiatry, which is one of the profession’s ‘...defining operational characteristic[s]...’ (ibid, p.293). They are, however, concerned about a reluctance to embrace the theoretical and therapeutic potential of neuroscience. They set out a model of scientific analysis that they consider helpful in formulating ‘...integrated mind-brain models that incorporate both the genotype and its expression in hierarchical and complex phenotypes of the brain...’ (ibid, p.293), as well as interactions between the physical and social environments. They admit that it will be several decades before any therapeutic benefits of this new neuroscience are realised. They reject the accusation that neuroscientific accounts of psychosis are reductionist, arguing that systems biology and ‘modern complexity theory’ will provide non-reductionist explanations of the interactions between genes, molecules and cells in understanding psychiatric disorders. Note that complexity here refers not to behaviour but to its biological correlates.

A third paper proposes a different view of the crisis. In contrast to the claims made for the ‘specific’ nature of psychiatric treatments, Bracken et al. (2012) propose that good psychiatric practice primarily involves engagement in the non-technical or non-specific aspects of care based in human relationships, meanings and values. The crisis of psychiatry arose partly because the ‘technological paradigm’ (diagnostic systems, causal models of mental distress, evidence-based medicine) obscured the significance of the non-specific aspects of care. In addition, it is seriously flawed. Empirical evidence from within evidence-based medicine indicates that the benefits people gain from many psychiatric drugs have less to do with their ‘specific’ properties than they have to do with the placebo effect, a non-specific element of care. This also holds for psychological therapies. The evidence suggests that it’s not the specific elements of CBT (for example) that are responsible for positive outcomes, but the quality of the therapeutic relationship as seen by the client. The paper concludes by setting out the challenge this poses for the future of psychiatry, and the need for a radical shift in the values base of mental health work. This involves a move to a post-technological psychiatry that, whilst not abandoning science and evidence, foregrounds the ethical and hermeneutic aspects of our work.

What does this crisis mean for professional relationships?
Psychiatry has always been held in a tension between different schools of thought about the nature of psychosis and distress. This reflects underlying philosophical problems concerning the relationship between brain and mind, and the mind and the external world. Until recently, this tension was regarded by many psychiatrists as something of value, that psychiatry was an ‘eclectic’ discipline, but many feel this is no longer so. Something has changed. We sense a growing intolerance to approaches to psychosis that are not grounded in neuroscience and genetics. Although the first two papers are not overtly hostile to non-neuroscientific or genetic approaches to psychosis, they barely receive a mention. There are two issues I want to raise: the relationship between science and clinical practice in psychiatry, and the relationship between psychiatry and other professional groups involved in mental health care.

The relationship between science and clinical psychiatry
The first two papers make strong claims for a psychiatry grounded in neuroscience and molecular genetics – a ‘medicine of the brain’. Craddock et al. claim that psychiatrists are ‘...trained in diagnosing physical and mental illness... [and are]... competent to formulate diagnoses that incorporate physical, mental and social factors...’ (ibid, p.7, emphasis added). This raises many issues. What are these ‘physical’ factors? Presumably, they mean unsubstantiated
biological theories such as the monoamine theory of depression and dopamine theory of schizophrenia. Bluntly put, unlike other branches of medicine there are no known physical factors that are aetiologically important in any psychiatric condition (except dementias) and that possess diagnostic, prognostic or therapeutic implications. There are, however, important caveats. The state of a person’s physical health and their mental state are inextricably linked. Some neurological disorders like multiple sclerosis are associated with profound changes in mental state, which risk misdiagnosis as psychiatric disorders. People with psychiatric diagnoses experience poor physical health and have reduced life expectancy (Casey et al., 2011; Wildgust et al., 2010; Chang et al., 2011; Laursen et al., 2012). The reasons for this are complex and include the effects of poverty and long-term consequences of neuroleptic drugs. All this suggests that medical knowledge and training are a necessary component of mental health care as far as the complex interface between physical illness and mental health are concerned.

Setting aside physical factors, Craddock et al. claim that psychiatrists are competent to formulate diagnoses that incorporate psychological and social factors. What are we to make of this? If, as the first two papers imply, all that matters about us as human beings, our emotions, beliefs and perceptions, is to be explained in terms of genes, molecules and neural networks, then what basis can a claim for competency in the assessment of psychological and social factors rest? It is worth noting that the words ‘mind’, ‘mental’, ‘psychological’ and ‘social’ do not feature in Bullmore et al.’s model.

There is evidence that the role of psychological and social factors has been marginalised in psychosis research. John Read and colleagues (2001) have argued that over the last thirty years the biopsychosocial model was transformed into the stress-vulnerability model. Psychosocial factors have become incorporated into the more general concept of ‘stress’, which in turn has been increasingly understood in physiological and neuroscientific terms, and ‘vulnerability’ is dominated by the concept of genetic vulnerability.

This makes it impossible to justify the claim that future psychiatrists trained in neuroscience and genetics will be competent to formulate diagnoses based in psychological and social factors. This hasn’t always been so. When I trained in psychiatry in Edinburgh in the late 1970s we were taught first to listen carefully to our patients’ stories and then make a formulation, of which diagnosis was only a part. Its purpose was to understand how and why the person had presented at this particular moment in her or his life history, and although opinions about the contents of a formulation differed, life events and psychodynamic factors featured alongside diagnosis (Hollyman & Hems, 1983).

A ‘medicine of the brain’ would remove our inner worlds, whether accessed through psychology or hermeneutics (narrative), from the frame in much the same way that some forms of behaviourism expunged the mind from psychology in the 1950s and 1960s. A psychiatry informed solely by developments in molecular genetics and neuroscience is one in which mind – our inner worlds – and the social worlds that our minds stand in relation to, are of no relevance. The gap between psychology and psychiatry would become a gulf.

Whose interests does psychiatry really serve?

The first two papers make claims for the power and authority of psychiatrists in the field of mental health. These claims are ostensibly set out on behalf of people who see psychiatrists, who according to Craddock et al., prefer to be called ‘patients’ rather than service users. The question that arises is to whom are they referring. Some people undoubtedly do find technological psychiatry helpful, and the authors are happy to engage with them. However, many people who use mental health services have much less positive views about psychiatry, and are critical of the role it plays in their lives. The real issue at the heart of the Craddock paper is that of leadership. They write:

...we were taught first to listen carefully to our patients’ stories...
Assessment, in many cases, may lead the psychiatrist, as a leader in the clinical team, to conclude that the most suitable treatment is a psychological or social intervention delivered by the member of the team with the most appropriate skills. (Craddock et al, 2008, p.7, emphasis added)

Their purpose is to assert the right of the consultant psychiatrist to lead mental health care. Over the last thirty years psychiatrists have been forced out of the Victorian asylums into district general hospital units, and more recently into the community, where it encountered challenges from the service user/survivor movement (e.g. Beeforth et al., 1994; Read & Reynolds, 1996; Faulkner & Layzell, 2000; Kalathil et al., 2011), and from other professional groups, especially clinical psychologists (Boyle, 1993; Johnstone, 2000; Bentall, 2003). It is vital for the future of psychiatry that it engages constructively with those outside who are critical of its theories and practices.

Conclusions
If the gap between our professions is to be bridged, there are four areas that require continuing effort from all professional groups involved in mental health care: the continuing democratisation of mental health services, redefining the role of medical practitioners in mental health care, the role of science in mental health care, and the prioritising the ethics of care over technology.

New Ways of Working was an important multidisciplinary effort to place team working in mental health on a more democratic footing to improve the quality of service and outcomes for people who use services. If we accept that the crisis means that change in psychiatry is necessary, the aim being a more limited, humble variant of the discipline, this confronts the profession with some difficult issues. Historically, medical leadership tied to diagnosis and physical treatment was used to justify consultant status and everything that came with it. The question is whether a future psychiatry grounded in neuroscience and molecular genetics is really capable of generating new insights into psychosis. My opinion is that the empirical, conceptual and philosophical difficulties are so enormous that the answer must be no (Thomas, 2014, Chapters 6 and 7).

If this is so then it is necessary to redefine the role of doctors in mental health care, and this has implications for training and education. Bracken et al. (2012) argue the need for greater emphasis on social sciences and the humanities to reflect the importance of the ethical and hermeneutic aspects of our work. There are strong arguments that clinical experience in primary care, neurology, public health medicine and a range of psychotherapies should feature prominently in the training of future psychiatrists. Prescribing skills will continue to be important because some people do benefit from psychiatric drugs, but the model here is Joanna Moncrieff’s ‘democratic drug treatment’ with a much more collaborative approach to the use of medication (Moncrieff, 2008, Chapter 13).

All this has implications for the type of science that is valuable in mental health practice. Epidemiological studies are valuable because they highlight those groups in society whose mental health is most at risk from contexts of adversity. In addition, as Joanna Moncrieff (2008) argues, there is an urgent need to reconsider the properties and modes of actions of existing psychotropic drugs. Almost all the existing research is based upon the discredited disease-centred model of drug action, whereas a drug-centred model offers a new way of thinking about how these drugs may be investigated scientifically, and used beneficially and less harmfully.

Finally, all professional groups need to recognise the need to balance future interventions that are likely to arise from new scientific insights into the relationship between adversity and psychosis with a deeper understanding of the value of care and compassion in mental health practice (Thomas & Longden, 2013) and the value of narrative as a framework for sustaining care and compassion, through which technology may be used judiciously (Lewis, 2011; Thomas, 2014).

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References


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Clinical Psychology Forum 261 – September 2014 35
I AM a 26-year-old service user with bipolar disorder and anxiety disorder, and I am a mental health activist. The following discusses individuals’ experiences with psychological services within the NHS, which I hope can be illuminating for professionals working in both psychology and psychiatry. Discussion of the problems and benefits of services as they currently exist will, I hope, encourage critical reflection on the way in which services operate and how psychiatrists and psychologists refer people and work with them in these systems, with an aim to reduce distress to service users.

Last year, I wrote about my experiences of short-course cognitive behavioural therapy (CBT), accessed via Improving Access of Psychological Therapies (IAPT). After eight sessions (four hours total), I concluded that:

’The problem as I see it is that CBT is seen… as a sort of magic bullet cure-all which is used to deliver fast results for individual problems… but people are more complicated than this. This, combined with a lack of funding for alternatives can have some pretty pernicious effects. As ‘service users’… we should be entitled to a whole range of psychological services based on our individual needs and circumstances.’ (Cosker, 2013)

I drew this conclusion due to several issues with the form of CBT as it was employed in my case. First was the problem of focus. I was referred specifically for anxiety-related issues, which also involved panic attacks and agoraphobia. While CBT was useful at getting me rehabilitated to living a fuller a life (e.g. being able to leave the house without panic), a substantial problem was my co-morbid bipolar disorder, which at that time was manifesting as a severe depressive episode. This made finding the motivation to do the exercises and maintain my confidence difficult, which undermined my progress. As my referral was specifically for anxiety, there was little to no time for working on the depression that was a clear maintenance factor in my anxiety symptoms. I can see the appeal, even necessity, of breaking problems down into ‘fixable chunks’; however, this can be problematic when there is no time to deal with co-morbid mental illness that is substantially complicating the picture.

A second problem was the lack of funding for ongoing support. Where I lived, the standard offer was 6–8 sessions (3–4 hours total). If after that you had shown some measurable improvement, you were discharged. I feel I was discharged too soon; left without support, making it hard to consolidate the progress I had made. A year on, I still find things that were my goals for CBT difficult to do, and sometimes impossible. I feel that if there had been more time and more money, then we could have worked on the depression symptoms that were also plaguing my life.

However, despite these two major problems, my time doing CBT was useful and well-spent, particularly as a starting point after years of entrenched anxiety-related problems which were severely impacting my life.

After moving house, I was again referred to Improving Access to Psychological Therapies (IAPT) by my GP. I have nothing but praise for the psychologist I saw, who was compassionate and honest about the services on offer. At that point, my bipolar medication had been changed and I was struggling with symptoms again. IAPT thus determined I was ‘too complicated’ for the basic service. This was disappointing, but I understood and was hopeful that this time I’d be referred for a more holistic approach that would deal with all my symptoms. IAPT did several hours of
Portraits of interactions with psychological services within the NHS

Table 1: Waiting times for psychological services within the NHS

<table>
<thead>
<tr>
<th>Time waited (months)</th>
<th>Percentage of participants</th>
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<tr>
<td>&lt;1</td>
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Assessment to try to ascertain which service would be most appropriate, then referred me to the Psychology Department for one-to-one psychotherapy. I waited, but heard nothing. At my next psychiatrist appointment, I was informed that I had been added to the list for a bipolar-focused group. This wasn’t what I thought I had been referred to, but I was pleased as it looked like I’d finally get some help with my more severe symptoms. At that point, I was told it would be around a three month wait. Two months later, a letter informed me that the wait would be until autumn 2014, charitably eight months more, and a year since I was first referred to IAPT. This was immensely disappointing and I was terrified that I was left to cope on my own.

Speaking to others

As a result of my experiences, I decided to speak to a wider group of people about their experiences. Using an online survey tool, I got a total of 45 respondents, with diagnoses ranging from depression and anxiety to bipolar, psychosis, and personality disorders. I am not claiming the responses I have constitute scientific research, but rather 45 individual portraits of interactions with psychological services within the NHS. I asked nine questions, covering all the main areas, from referral to outcome. Fifty per cent of the responses related to experiences within the last year, 80 per cent within the last five years.

I started by asking people about their experiences of the referral process, particularly waiting times. The results are presented in Table 1.

Clearly, the 30 per cent who waited two months or less received timely care (this includes some respondents who were in-patients). Several people commented specifically about how long the referral process and waiting lists were, describing it as ‘long and arduous (respondent 20)’, with another saying it was ‘long and vague and intimidating’ (8), and a third explaining how they had to ‘push and complain and call in tears several times’ (28) in order to secure an appointment. Many commented specifically on how difficult it was not hearing anything until the initial appointment, with ‘no acknowledgement of being on the waiting list or how long the wait might be’ (1). Another commented that, ‘nobody told me what was going on, I had to chase up information myself and felt like I was being bumped around from person to person without any regard for me’ (15). This problem was essentially summed up by respondent 46, who stated:

...nobody told me what was going on, I had to chase up information myself...

I felt forgotten and alone once the referral for an assessment took place. There were no periodic reassurances and no communication to confirm that things were progressing. This caused considerable anxiety and contributed to depressive episodes.

1 Respondents to the survey ‘Experiences with psychological/talking therapies’, undertaken 29 January 2014–5 March 2014, are subsequently identified by number. Thanks to all respondents.
Also highlighted was the amount of distress the referral, waiting period and assessment process caused a significant portion of the respondents. As one response recounted how services ‘took a lot of personal and triggering information without much warning… I was given no aftercare’ (44). What is concerning is that the way some current processes function actively makes the situation worse for some people, leaving them feeling abandoned while they wait on services they desperately need. There seems to be little awareness that the assessment process can itself be traumatic, as people are asked to divulge sensitive and upsetting information without any chance to build trust. In some cases we were then deemed ‘inappropriate’ referrals or too high risk and were then referred on, meaning that we have to repeat this process over and over while professionals attempted to ascertain which services were appropriate. All while not actually receiving any therapy and leaving us alone to cope with the fallout of this process.

Several respondents were not made aware of the type of therapy they were being referred to. A further subset were then told that the services provided were ‘inappropriate’ for their needs, without an explanation of this, and were then referred on to a further service, with one commenting:

‘I was never really sure what I was being referred to… I just kept getting told that what the service provided wasn’t right for me, despite not really knowing what the service in question provided.’ (15)

For one respondent, this had devastating consequences as the continual referral-assessment—rejection’ process meant that it took them a year to finally get to a service that was appropriate for them. They commented, ‘This is a big IF, but if I had been referred to this service initially… then my job might of been saved and I may well be in a different place now’. (30)

As for the services provided, a key finding was that when services work well, they work really well, radically changing people’s lives and improving their mental health. There were positive stories of people whose main message to the psychologists they worked with would be ‘thank you’.

Forty-six per cent of respondents had had some experience with CBT. Some had very positive experiences, but many of the comments reflected my own experiences about the specificity of the focus and the brevity of the sessions. Respondent 23 directly mirrored my experiences: ‘I am being asked to focus on social anxiety, when depression is much more of an issue just now’. Others reflected feelings that the CBT was too short: ‘When it finished I felt a little bit like I was being thrown out on to the street without a safety net’ (20). Moreover, some felt they were being asked to accept some progress without making the recovery that they had hoped for: ‘…was still not fully recovered but told to accept that my eating disorder behaviour was less frequent so that’s probably best I was going to achieve’ (16).

Overall, a significant portion of the respondents experienced many of the problems outlined in the previous section. Possible solutions to these issues range from the simple to the much more complex and structural. For example, I would suggest:

- generally increasing communication during the referral process; and
- keeping people updated with the progress of their referral and then when and where they are on the waiting list.

These solutions could be implemented relatively easily, making a vast difference to people by decreasing the feelings of anxiety and abandonment that often accompanied the process. Meanwhile, more systemic issues such as the brevity of CBT and its deployment as the first line treatment would require more complex solutions.

**Specific issues**

A myriad of specific issues were also raised by respondents. These ranged from marginalised groups having negative experiences with serv-
services, to problems negotiating services while at university, or when transitioning from Child and Adolescent Mental Health Services to adult services. Unfortunately, I lack the space to do all of these issues the justice they deserve. Instead I will very briefly focus on two specific issues: The first relates to the experiences of marginalised or vulnerable groups within services, and the second a specific issue related to working while experiencing mental ill-health.

Several of the respondents referred specifically to horrendous experiences that they had had as trans people with mental health problems. One respondent recounted their experiences of transphobic counsellor working within NHS services, while another gave a specific example of how they had been consistently misgendered by a refusal to use correct pronouns, both in person and in writing. The Trans Mental Health Study 2012 (TMHS) found that within mental health services, 29 per cent of respondents ‘felt that their gender identity was not validated as genuine… 17 per cent were also told that their mental health issues were because they were trans’ (McNeil, Bailey, Ellis, Morton & Regan, 2012). The experiences of the respondents are in line with these findings. Moreover, 88 per cent of the respondents to the TMHS felt that they either currently or previously suffered depression, with stress at 80 per cent, and anxiety at 75 per cent (ibid). From these statistics it is clear that there are a significant number of trans people who are potentially in need of input from psychological services, who may feel unable to do so due to prejudice and discrimination: 35 per cent of the TMHS respondents who had needed urgent help had avoided seeking it due to being trans or having a trans history (ibid). Clearly, experiences of the respondents I spoke to form the backdrop of this statistic, with people legitimately worrying about how professionals will treat them. One relatively straightforward approach to begin to help ameliorate this problem would be decent education or training for mental staff specifically regarding trans issues. One respondent suggested that reading the TMHS should be undertaken by all staff so that they can begin to understand the specific issues facing members of the trans community seeking help from psychological services.

A second subset of responses that stood out where those of abuse survivors. Issues were raised specifically about the lack of awareness on the part of staff about how abuse could be an underlying contributory or causal factor in people’s mental health problems. According to statistics from Women’s Aid, ‘between 50 per cent and 60 per cent of women mental health service users have experienced domestic violence, and up to 20 per cent will be experiencing current abuse’ (Women’s Aid, 2005). So clearly, good training about the relationship between abuse and mental health problems of services users is essential. Moreover, specific issues such a mixed-gender groups or women being offered male staff after specifying that they would only be comfortable seeing a female therapist were also highlighted. This raises questions about understandings of the aftermath of abuse and the need for sensitivity. Work on this issue can and must be done to address the specific needs of this already highly vulnerable group.

A further specific issue highlighted was the difficulties experienced by people continuing to work whilst undergoing therapy. Several respondents commented on the limited hours available for services, which were during working hours, making it difficult for people to continue working without taking time away from work or having to disclose their mental health problems. One respondent, 17, specifically commented:

Working is a big protective factor in terms of my mental health, so it’s not helpful asking me to disrupt my work life by taking so much time off to attend appointments. Also, to take off a half day each week to attend appointments would effectively force me to disclose my mental health problems to my employer, which I don’t want to do.
Conclusion
Overall, there were many problems highlighted by the responses I received, but what also stood out was how positive psychological services input can be when done well. There are many problems with services as they are, but there were also suggestions made for positive change. Hopefully, with changes to address the problems and overcome some of the barriers that currently exist these good experiences can be accessed by more people. I remain optimistic that better services for people experiencing mental ill-health are possible. I would hope that via critical reflection on services as they currently exist, psychologists and psychiatrists can work together to reduce the stress and strain placed upon people being referred into these services by working on the problems outlined above, both in terms of service design and delivery, and through more appropriate referrals into services.

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References

The British Psychological Society
Research Board

Research Seminars Competition 2014

The Research Board invites submissions

Aim – To enable a minimum of two institutions in co-operation with each other to hold a series of at least three scientific seminars, involving a minimum of 10 people, within a period of about two years. Grants – four grants are available, each worth up to £3000, to meet the travelling and accommodation expenses of those attending the seminars. Institutions should be able to arrange and meet the costs of the rooms.

Criteria – The seminars should have tangible goals, explicitly focused upon extending and developing the understanding of psychological processes in any field of scientific psychology.

Applications – As a minimum of two institutions will be involved, submissions should be made by a primary applicant and a co-applicant, at least one of whom should be a Society member.

For further details and an application form please contact liz.beech@bps.org.uk.

The closing date for applications is 26 September 2014.
WHEN THE PLANNING for a new sister journal to The Lancet began, the first problem we faced was what to call it: The Lancet Psychiatry, or The Lancet Mental Health. It wasn’t an easy decision to make. I worried that some might think ‘psychiatry’ implied an exclusively biomedical approach, and that it would alienate other professionals such as psychologists and community nurses. On the other hand, use of the terms ‘health’ and ‘illness’ is not without controversy. Ultimately, I chose The Lancet Psychiatry as the title, not only because I anticipate – and hope – that the journal will become essential reading for psychiatrists, but because if the word ‘psychiatry’ means anything to me, it is integrated care, which includes a medical element. It doesn’t imply primacy of a biomedical model. In editing this journal, I hope to provide some answers – or at least ask the right questions – as to what the future of care of those in mental distress should be. It is a future inseparable from psychology at every level, from basic research to clinical practice.

The dispute over DSM-5 in 2012 was oversimplified by some as a battle between ‘psychology’ and ‘psychiatry’. Like many things in mental health, a pattern that seems clear from a distance dissolves upon closer examination. The criticisms of DSM-5 came from, among others, those who thought its revisions made it a weaker manual than DSM-IV: those who thought it promoted a restrictive biomedical approach, those who thought its approach was not biomedical enough, and those who saw it as the manifestation of everything that was wrong with the past century of a medically-driven model of mental health care. The British Psychological Society’s Division of Clinical Psychology released a position statement, Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a paradigm shift. There is much sense in this document, though I am unsure whether what it defines as a ‘paradigm shift’ – ‘an approach that is multifactorial, contextualises distress and behaviour, and acknowledges the complexity of the interactions involved in all human experience’ – is really as radical a proposal as the phrase would imply.

I think of the DCP’s proposal not as a quantum leap, but as the ideal that multidisciplinary care teams strive towards. The fact that this is labelled a ‘paradigm shift’ suggests to me that something has gone seriously wrong, both in some areas of practice, and in the understanding between individuals providing support to those in mental distress. I wonder how things became so divided, and it worries me. As Harvey Pekar said, ‘Ordinary life is pretty complex stuff’. Whatever term one uses to describe the experiences of people with problems relating to delusions, hallucinations, depressed mood and other problems, the best way to help will not result from the triumph of one particular model or profession.

The advantages of the psychological approach are clear: among other things, psychologists can explore personal history, context and the meaning of symptoms to the...
patient, as well as delivering safe and effective therapies. High-quality psychological research can make a substantial contribution to the understanding of mental health problems and to the development of new approaches to care. The contribution of medicine, meanwhile, does not begin and end with the prescription of psychotropic drugs. Good medical training should provide awareness of the many factors that lead people to seek help from professionals. It should encourage an empathetic and open-minded approach to the problems people experience in their lives. Psychiatrists, with their extensive experience of other medical disciplines, are able to address the appalling physical health problems that so often accompany mental distress, poverty and social exclusion.

Unlike some, I do not believe that the investigation of biological factors relating to, for example, delusions and hallucinations has yielded all that it can. As psychologists and psychiatrists, we are working in a field in its infancy. The challenges are more formidable than those faced in any other area of biological and social science: I would be tempted to compare them, in their daunting complexity, to those investigated by particle physicists. Without dialogue between disciplines, we will fail both ourselves and the people we wish to help.

Where should this dialogue take place? The growth of social networks has been a welcome development over the past few years, and brings professionals from all areas, as well as service users, into contact. However, I often get the sense of positions being restated and entrenched, without actual progress being made. My response to Twitter has ranged from amusement and enlightenment to a headache and a sense of being mildly irritated with myself. Public debates are enjoyable and informative, but by their nature ephemeral. This is where I believe journals come in. The dominance of online publishing means some believe the journal has had its day: that the future lies in the access of individual papers, not a cover-to-cover read. I would argue – and I have a clear conflict of interest here – that a journal should do more than just deliver information. In mental health care, perhaps more than any other area, a journal must strive to be a forum in which the future of the caring professions can be debated and shaped. Journals can and must do better at bringing psychiatry and psychology together. We can do this through encouraging joint research, through publishing review material from multidisciplinary groups that aims to integrate different approaches, and by thinking about the content and balance of our non-research material. Most of all, we can do it by listening to what service users want, and making sure we share their priorities.

My philosophy – and that of The Lancet Psychiatry – is therefore not Freudian, or Lacanian, or cognitive behavioural, or biomedical. It’s best summed up by Kurt Vonnegut: ‘God damn it, you’ve got to be kind.’

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References
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Interview

Tanya Byron: Get visible or disappear

PROFESSOR TANYA BYRON is one of the best known clinical psychologists in the UK. Her portfolio is diverse. She has had three successful television programmes Little Angels, The House of Tiny Tearaways, and Am I normal? She co-wrote the sit-com The Life and Times of Vivienne Vyle with Jennifer Saunders. On the radio she has hosted All in the Mind, she has regular columns in broadsheet newspapers and has published a number of books, the latest of which has just been released: The Skeleton Cupboard: The making of a clinical psychologist. She has produced two significant reviews for the government: The Byron Review: Safer children in the digital world (2008) and Do We Have Safer Children in the Digital World? (2010). In addition, she is Professor for the Public Understanding of Science at Edge Hill University, and after all of this she still manages twenty-five hours of clinical work a week. I met up with her earlier this year to find out her views on where the profession should be heading with its media presence and engagement in public activities. When we met she was both frustrated about how things are now and passionate for change.

Tanya’s transatlantic work has given her useful insights: ‘I work in the UK and the States. In the States the visibility of clinical psychology as a profession is huge. There is variability in the quality of what is being said, but fundamentally everybody knows what a clinical psychologist is; they have parity with psychiatrists, they are seen as having a particular skillset for making social comment. I just do not see that here in the UK.’

She suggests that we need to address this situation as a matter of some urgency. Otherwise, she thinks, a combination of cuts and the provision of psychological therapies by non-psychologists mean that the profession is doomed: ‘Unless people feel that they cannot do without us, the profession is never going to get the support it needs at public level.’

In her call to arms she stresses the need for support from our professional body, the British Psychological Society, but she was not confident that it would be forthcoming.

Tanya is not sure how well the Society supports applied psychologists in having a public and media presence. She used an example of a letter from The Guardian signed by CEOs of mental health charities and Sue Bailey from the Royal College of Psychiatrists that raised concerns about mental health cuts. There was no BPS signature on the letter. Tanya considers that clinical psychology is behind the game in both media presence and the use of social media for disseminating our evidenced-based psychological understanding and interventions together with promoting our profession. While this remains the case, she believes that clinical psychology will always be ‘the bridesmaids and second cousins of psychiatry’. She lamented that: ‘We are so invisible!’
Media training
Working with the media or using social media in a professional context can be anxiety provoking, so clinicians need training in the skillsets needed for this area of work. Clinical psychology trainees at University College London benefit from a course that Tanya teaches in working with the media and using social media, which utilises her vast experience of print, radio and television. The course covers issues such as not allowing your message to be diluted or presented in ways that allow unwanted editing later, resisting producers’ requests to say it again but in the style they want. This is all very useful stuff. However, such courses are a rarity elsewhere in the UK. Yet as Tanya pointed out, current trainees bring a wealth of experience of social media use from their personal lives: ‘the new generation coming up are media savvy’. And hungry to use it as part of their work. But Tanya feels the profession as a whole lags behind: ‘Why are we so in the twentieth century about this…? I feel we are way behind other professions’. It is a sad reality that the Society has stopped running media training courses.

Adapting the skills we already have
Tanya told me how clinical psychologists need to adapt their communication to fit with media conventions. Doing so does not necessarily mean ethical compromise: ‘People in the media need sound bite. That’s how the media works. My argument is that, so long as we are robust and evidence based and able to say that this is one way of looking at it, we are a gateway to people’s thinking. We give people the opportunity to go and explore further.’

The converse is also true of course. If we do not engage with the media, others will, and will offer psychological opinions that may not be as robust or as evidence based as a clinical psychologist’s. Service users and carers could be left without information that might change their lives.

It is reassuring to know that we already have many of the skills needed to produce media friendly messages. As Tanya states, every day in our clinical practice we explain psychological concepts in a way that people can understand: ‘We create narrative, we use formulation, so we know how to take a very complex history from a person that we are working with as practitioners and build it into a simple, understandable narrative for that person in order to enable them to engage in a therapeutic process with us. Well, it is exactly the same for the media. That is what we need to be making. That is what we need to be doing.’

Different forms of media require different ways of working. For example, with print media the clinician has more control; they have a set number of words to explore the issues as they want. However, this does require the clinician to have a good level of skill as a writer and it cannot be taken for granted that achieving a Doctorate leads to this level of skill. With broadcast media, on the other hand, the clinician needs to develop a relationship with the programme maker and negotiate how to communicate the message. This would suit some clinicians, but not all. There will be compromises; for example, choosing the programme’s title in order to get a hook. Tanya cites the title The House of Tiny Tearaways, which would not have been her first choice, but as she said: ‘Sometimes it is about headlines, because if we want people to watch there has got to be a hook.’ However, creating hooks does not mean giving up values.

Ethics count and the media is not the dark side
Whatever form of media a clinician might use they still need to remember the values of their profession; not just being evidence-based, but also maintaining their responsibility to their clients, as Tanya is well aware: ‘We have a huge duty of care. Even in my Times page, where stuff comes in, if I do not reply to it but it needs to be replied to, it will get dealt with; people will get signposted, advised. There is this idea that we dip into the media, do stuff, exploit people and drop out. It’s not how it works.’

Some productions are exploitative but they are rare, soon found out, and do not produce good work. In thinking negatively about the media clinical psychologists may be stereotyping, as Tanya suggests: ‘It isn’t the dark side… there is this sense that the media is there to suck us in, chew us up and spit us out, which is just not true.’ So in making good ethical programmes, usually there will not be the battles with the production company that people might fear.
Standing up and speaking out
Another area where Tanya believes that the profession needs to be bolder is in putting forward our views and our evidence base in public activities such as Home Office Select Inquiries. She described a recent experience of trying to get clinical psychologists to put forward evidence to a select committee on the crisis in UK Child and Adolescent Mental Health Services. However, she was faced with anxious clinicians unwilling to present evidence. She told me that one source of anxiety for the clinical psychologists was that they might not be following the BPS line; some had been ‘wrapped over the knuckles’ for this before. Another source of anxiety was that they might be seen as whistleblowers by their employing Trusts, even though what they were doing was not whistleblowing. Tanya believes that professional backing is vital to shift this anxiety: ‘If we have a strong professional body that sits behind us and we feel empowered to be able to say things that are difficult to hear at a policy level, we have so much that we need to say, so much concerns within our profession. There needs to be a sense of unity as a profession and a sense of being supported by the profession as a whole and in particular by the professional body.’ With such backing we would be able to use our skills to full advantage in this area.

Tanya believes that our training makes us potentially very helpful to policy makers: ‘What we are really good at is built about our ability to formulate so we can set parameters on an issue.’ This is a set of skills that policy makers find useful as we are able to deal with complexity, balance different arguments and come up with a set of workable proposals. In addition, we would make sure that the people the policy concerns are not lost in the process: ‘We hold that individual person-centred approach and that is fundamentally important in terms of supporting policy makers.’ Tanya considers that the Society needs to be more proactive in making sure that psychologists are present at relevant select committees. She considers that we need a register of clinical psychologists for such purposes as she is left almost despairing: ‘Why do we not just deploy our people?’

The Society needs to be less reactive, but instead pushing things forward – being proactive for a change.

Another type of commissioner we need to be working with
Tanya believes clinical psychology needs to get more involved as a profession in offering ideas for programmes to major public broadcasters such as the BBC, Channel 4 and National Geographic. She told me that when she goes to the commissioning rounds for programmes clinical psychologists are not present: ‘in the commissioning rounds why is our profession not sitting there offering up stories? Medics are, psychiatrists are. Because they understand that this is the way they strengthen their profession, they get society to think that they cannot do without them and therefore policy makers have to continue to fund what they do.’ A greater involvement in mainstream broadcast media is something clinical psychology needs to engage in to maintain the funding of our profession and what we offer to service users and carers. It is not the main thing, but it is an important one that the profession has neglected. However, it does not have to be left until those at the top get the house in order, everyone can play a part.

Everyone can play their part
Tanya feels that every clinical psychologist should take responsibility for building the profession’s media presence. If we have something to say we should Tweet about it, phone radio programmes, write letters to the newspapers to make sure that we are visible. If we become aware of a mental health story that we do not think is being covered well or accurately, we should get involved.

If a clinical psychologist is not interested in working at a national level in relation to the media but is interested in their locality, there are many opportunities here too: ‘Use local media, local news. Local papers are more community based. Local radio is really powerful still… local media is incredibly powerful… Get a column in the local newspaper, a column in the Trust bulletin, that is clearly branded that you are a clinical psychologist.’
Tanya makes sure that her brand when she writes in the *Times* and *Good Housekeeping* is Tanya Byron, Clinical Psychologist.

Taking it one stage further would be to get involved in the media in a paid capacity as Tanya has done. Tanya began after the birth of her first child, when she wanted to work part-time, by writing for gym and sports magazines. She then became a consultant on storylines for soaps, then an adviser on mental health programmes and then came her own programme. She still sees the progression that she followed as ‘a way in’ to this line of work. However, there is now a new way to become involved, through blogs: ‘The blogosphere is looked at hugely by print and broadcast media editors. So just create your own brand, your own space, your own place where you think about your message, what you want to say and how to say it.’

**Plans for the future**

When considering where the profession should be heading in relation to the media and public activity it became clear that there were issues to be overcome. In order to develop a more effective engagement between clinical psychology and the media the following four areas have to be addressed:

1. **Overcoming anxiety:** We need to overcome our anxieties about working with the media and using social media. This needs to be addressed at all levels of the profession and cover the anxieties of the individual, the employing Trust and the British Psychological Society.

2. **Media training for all psychologists:** All trainees would benefit from being put in front of a camera and given eighty seconds to comment on a clinical psychology issue and then being given feedback.

3. **Professional support:** We need better support from our professional body, the BPS, and with a clear steer. This will help reduce anxieties about working with the media right across the profession.

4. **More role models:** There is a need for more role models of clinical psychologists with a media presence as they are still something of a rarity.

As part of this initiative perhaps the profession can look to the US to find out how clinical psychology has become so influential there.

What of Tanya’s plans for the future? Well, after fifteen years in the media she is still enjoying it and plans to keep doing so. In this she finds the support of those around her – family, friends, agent, PA, clinical and media colleagues – to be vital. To do this kind of work long-term you do need a team around you; you need to have ‘the structures in place to support the activity.’

Tanya plans to remain clinically active too. She told me how she has found her media work to be an enabler in her clinical work rather than a hindrance, as having seen or read her work people come to see her with the belief that ‘she can help me’. Those fifteen years in the media have not affected what she sees as her priority and where her passion still lies: ‘Someone called us celeb-demics the other day, which makes us sound like a venereal disease. But I am somebody with a professional background who works in the media. I am a clinical psychologist first and foremost, and it’s that which I enjoy most, clinical work.’

**Interview by Stuart Whomsley**

*DCP PR & Communications Lead*

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Stuart Whomsley

*DCP PR & Communications Lead*
Clinical Psychology: 
A critical examination
by Craig Newnes

Reviewed by Tony Wainwright

Craig NEWNES, for those who need an introduction, is a past editor of the Clinical Psychology Forum, and for many years, until 2007, led a very successful department of psychological therapies in the NHS in Shropshire. He has published numerous articles and books and has been a critical voice in clinical psychology during his lengthy career. He is now (semi-) retired and his latest volume provides a critical perspective on the profession of which he has, for so long, been a part.

The book’s main contention, which is explored in different ways, is that the profession of clinical psychology has a core problem, which he sums up as follows:

‘For a supposedly reflective profession, clinical psychologists have shown little interest in examining their wider role in maintaining the status quo and, until very recently, have failed to adequately criticise the inherent contradictions and lack of validity in psychiatric disorders.’

I was reminded while reading the book of a recent ethics column by Bender (2014) discussing the profession’s position in the field of dementia care which makes some similar points. Craig argues that complicity in an unhelpful and damaging dominant narrative has been one of the hallmarks of our professional identity.

The book is divided into eight chapters, and the all but three have titles starting with ‘Problems with…’. These include problems with ‘theory and research’, ‘assessment: pathologising difference’, ‘practice: effectiveness and informed consent’, ‘practice: pathologising childhood’, and ‘practice: pathologising adults’. Each chapter describes the author’s views on the position clinical psychology has taken in each of these areas finds it wanting.

Craig’s style is consciously unacademic. His account of his early career working in a rope factory, then at Birds Eye Foods, and finally, as a ceiling tiler before entering the profession is a backdrop, and informs the underlying message that clinical psychology and the wider psychology profession is a privileged group who have a conflict of interest as they make money out of other peoples distress and poor living conditions. He also provides honest accounts of his own life, and the experience he has had as a practitioner.

Throughout the book, Craig makes many assertions that are not well referenced, and while giving much food for thought readers should enjoy further researching these controversial points.

He says in the introduction that this is not a balanced account: it is one-sided and biased. However, he is not apologetic for this because, he says, there are many books and journals that provide support for the status quo – this is certainly not one of them.

References
Extraordinary Demands in Ordinary Services: Establishing family intervention for psychosis in routine care

Wednesday 22 October 2014, 9.30am–4.00pm
BPS London Office, 30 Tabernacle Street, London EC2A 4UE

Since the evidence base for family intervention for psychosis was first established – and particularly since publication of the first NICE guidelines for schizophrenia and psychosis in 2003 – psychologists have been involved in trying to deliver and increase access to family intervention. For most of us this has proved to be a complex and challenging task. Responding to feedback from the network membership, we are arranging this event to promote discussion about different routes you could take within your services to develop family intervention. Our speakers are all committed to improving services for families in routine settings and together we’ll consider how to grow things in your service on a scale that feels achievable.

Speakers
The day is facilitated by Network Leads Maria Griffiths and Sophie Holmes. Speakers include:

Lucy Hickey and Mel Bunyan Oxleas NHS Foundation Trust
Rumina Taylor & Nicola Gawn South London and Maudsley NHS Foundation Trust
Jo Smith Consultant Clinical Psychologist

Free event for members only
If you are not a member of the Faculty of Psychosis and Complex Mental Health and wish to attend the event you will need to join the faculty first.

If you have any queries, please e-mail MemberNetworkServices@bps.org.uk, with ‘Family Intervention’ in the subject line.

This event is being financially supported by the DCP Faculty of Psychosis and Complex Mental Health, which has invested in it for the benefit of members.

To book, go to:
https://response.questback.com/britishpsychologicalsociety/finetwork
Pressing workforce issues
A major theme at our annual strategy event was the additional burden on members resulting from the continuing pressures on psychology posts and salaries.

Alison Longwill presented her work she had been commissioned by the DCP West Midlands Branch to map the psychology workforce (www.bps.org.uk/networks-and-communities/member-networks/division-clinical-psychology/resources). This work was triggered by the decision of the local education and training board to cut local clinical psychology training posts by twenty-five per cent and the likelihood of further deep cuts in the pipeline. The local training board plans to ‘reduce its dependence on clinical psychology and use the money saved to upskill the workforce in psychological skills’. We are raising concerns locally and nationally about the inaccurate baseline data they have used, their failure to consult with the profession, or to scope the future need and demand for clinical psychologists, or to assess the impact of their plans on the implementation of national strategies which require additional psychological expertise. The evidence on the ground is that newly qualified staff are continuing to find employment and it may well be that over the foreseeable future the West Midlands will import staff trained and funded by other regions.

The national workforce plan for Health Education England (HEE) indicated that we would see training place for next period remain at the current level. The West Midland situation highlights the problems of relatively small professions being commissioned by local groups. The whole structure of health education training is yet again up in the air. HEE have decided to appoint four new HEE regional directors to cover the whole of England and this may well reduce local autonomy.

The plan following on from the strategy event is to strengthen our workforce data and intelligence. We intend to urgently build on Alison’s work by establishing a UK-wide baseline for clinical psychology staffing. In particular, we plan to: pull together all the differing strands of workforce activity across the nations, regions and specialities; report on current and projected demand; and last, but by no means least, survey and report on the strategies that have been used to mitigate the impact of the cuts in posts and grades. Catherine Dooley has taken over from Tim Cate as Chair of the Society’s Workforce Planning Advisor’s Standing Committee. We will be working closely with her and the other applied divisions.

English Branches
DCP London Branch have commissioned a report on how the profession is configured and represented. The Branch plans to strengthen its links with the London Regional Psychology Advisory Committee (the heads of psychology committee) and help increase the profile and influence of the profession in the capital. A fifth of our entire membership is based in London. Getting our profile right in London is crucial given their proximity and easy access to Westminster.

Congratulations to Annie Mitchell, the newly elected Chair of the reformed DCP South West England Branch. It was great to attend their relaunch event in Plymouth.

The Scottish referendum and the general election
We haven’t discussed the implications of a Scottish ‘Yes’ vote. I would not be surprised to see the formation of the Scottish Psychological Society. The division of the Society’s ten million pounds of reserve cash might well prove problematic.
In preparation for the General Election, Richard Layard and David Clark organised a very good cross parliamentary event at Westminster to try and influence the three main party’s manifestos. Layard argued for a doubling of the IAPT programme. There was again, ironically given the Child and Adolescent Mental Health Services budget cuts, a call from all concerned for more resources for children’s services. Over ninety MPs and peers have joined the Westminster mindfulness programme. Labour have used freedom of information to expose ‘the alarming postcode lottery’ in the funding of mental health in England (tinyurl.com/2nd-class-mh). The pre-election news is that it looks like Monitor and NHS England are going to drop the scandalous ‘differential tariff deflator’ which effectively cuts mental health budgets by 20 per cent more than the acute sector. It is a sign of the times that a reduced efficiency saving is something to celebrate.

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| DCP CPD workshops |
|-------------------|-----------------|----------------|
| EVENT | VENUE | DATE |
| From ice breakers to creating connections to farewells:  
Group facilitation  
Dr Virginia Lunsden MBPsS & Mandy Sarankin | BPS London office | 07 Oct 2014 |
| Facilitating preferred changes using narrative approaches for children and adults with physical health problems  
Dr Lincoln Simmonds CPsychol and Dr Louise Mozo Dutton CPsychol | BPS London office | 17 Oct 2014 |
| A reflective-relational-systemic approach to forensic psychology: Bringing your family to work  
Professor Paula Nicolson CPsychol FBPsS | BPS London office | 11 Nov 2014 |
| Working with adolescents who display high risk behaviour from a developmental trauma & attachment perspective  
Dr Andrew Rogers CPsychol AFBPsS & Dr Lorraine Johnstone | BPS London office | 17 Nov 2014 |

www.bps.org.uk/findcpd

The British Psychological Society Learning Centre

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Dr Jennifer Wild, Consultant Clinical Psychologist & Senior Lecturer, Institute of Psychiatry

‘The selection of papers suits my eclectic mind perfectly, and the quality and clarity of the synopses is uniformly excellent.’
Professor Guy Claxton, University of Bristol
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Contents

Regulars
1 Editorial
   Stephen Weatherhead
3 Caption competition
4 DCP Notification – DCP Annual Conference 2014
   Cath Burley
6 Ethics Column – First do no harm
   Sami Timimi
9 DCP Experts by Experience Column – Don’t get boxed in
   Simon Mudie
44 Interview – Tanya Byron: Get visible or disappear
   Stuart Whomsley
48 Review – Clinical Psychology: A critical examination, by Craig Newnes
   Reviewed by Tony Wainwright
50 Notes from the Chair
   Richard Pemberton

Articles
12 Sharing the shadow
   Gordon Milson
16 The relationship between psychology and psychiatry: Reflections of a trainee clinical psychologist
   Sarah Davidson
19 Whose fault is it? A medical student’s view on how the divide between psychiatry and psychology is perpetuated in undergraduate education
   Lauren Evans
22 Teaching on diagnosis: An interprofessional reflection
   Ranil Tan & Remy McConvey
26 Interview with a service user, a psychologist and a psychiatrist
   Charlotte Walker, Ruth Ann Harpur-Lewis & Alex Langford
31 Professional relationships and the crisis in psychiatry
   Phil Thomas
36 Portraits of interactions with psychological services within the NHS
   Zoë Cosker
41 Pretty complex stuff: An editor’s perspective on psychiatry and psychology
   Niall Boyce