Clinical Psychology Forum

Special Issue: Diversity

Clinical Psychology Forum

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News

NICE guidelines on self-harm

PSYCHOLOGICAL interventions should be offered to people who self-harm to help them overcome their behavioural problems, latest NICE guidance suggests.

Healthcare professionals should offer 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm.

The intervention should aim to reduce self-harm and should be tailored to individual need and could include cognitive-behavioural, psychodynamic or problem-solving elements.

Therapists should be trained and supervised in the therapy they are offering to people who self-harm. Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Professor Tim Kendall, Director of the National Collaborating Centre for Mental Health who helped develop the recommendations, said: 'Self-harm is very common and involves a wide range of methods, the most common being self-poisoning with prescribed or over the counter medicines, or by cutting.

'People self-harm for numerous reasons, and although self-harm is not usually an attempt at committing suicide, it is a way of expressing deeper emotional feelings, such as low self-esteem, the emotional results of previous abuse and hurts.

'However, people who self-harm are much more likely to die by suicide, and many suffer from long term physical effects of self injury and self poisoning, as well as psychiatric problems such as depression. It is very important that we help identify people who self-harm sooner and to help them come to terms with the underlying problems and access treatment when they need it. This guideline is a really important step to achieving this'.

The New Savoy Partnership has issued a statement calling for further research and methodological innovation to support the use of a wider range of evidence-based psychological interventions in the development of NICE (National Centre for Clinical Health and Excellence) guidelines. The Partnership is a group of organisations, including the British Psychological Society, who work together to bring psychological therapies to the NHS and improve access for all who need them:

'NICE guidelines have provided the evidence base for a major expansion in the provision of psychological therapies by the NHS. NICE is well regarded for its use of robust methods to evaluate the best available evidence. Concerns have been raised, however, about whether the range and balance of evidence considered and treatments currently recommended is too restrictive.'

It therefore goes on to call on government, clinicians, academics and research funding bodies to work together to support investment in high quality research on psychological therapies.

The statement says the Partnership will encourage professionals and patients to collect and report on routine outcomes. And it urges NICE to make best use of the new evidence that will emerge from this work to support:

■ patients in making informed choices on evidence-based psychological therapies;
■ clinical commissioning groups in making intelligent decisions on commissioning an appropriate range of evidence based psychological therapies for their patients
■ providers in making well-informed judgements on what evidence-based psychological therapies to offer.

In conclusion, the statement says the Partnership's intention is to build a wider consensus amongst academics, clinicians, professional bodies, mental health charities and others. It will also seek to use the priorities and principles agreed in the statement as the starting point for undertaking work collaboratively to achieve further progress.

Wake up to sleep

THE DIVISION'S Annual Conference, which took place in Birmingham on the first two days of December 2011, was a great success, with a programme full of distinguished speakers, a notably friendly atmosphere and over 250 psychologists attending. *Clinical Psychology Forum* will be publishing the full proceedings as a supplement early in the new year, so in this report we just look at a couple of the highlights.

On the evening before the Conference, Professor Colin Espie gave a public lecture under the title 'Wake Up to Sleep'. Speaking to an audience of 150, which included psychology students from several Birmingham sixth forms, he gave an entertaining survey of the importance of sleep to our health and wellbeing.

Two of his observations stood out. He reminded listeners that the symptom that people who seek help for mental dysfunction complain of most often is difficulties with sleeping; and he remarked that only people with insomnia have 'a strategy for getting to sleep' – other people simply fall asleep.

The afternoon of the conference's second day (Friday 2 December) saw a symposium on the commissioning of NHS mental health services. It was chaired by Professor Peter Kinderman, the Division Chair, and Pam Skinner, the Chair of the Division's West Midlands Branch, and included Professor Sir Steve Field, the Birmingham GP who chaired the government's listening exercise on NHS reform, among its participants.

Sir Steve described the listening exercise he was asked to conduct when the Coalition's proposed health reforms encountered public and professional opposition. He put together a team of 43 to help him, met 6500 people and read his way through 2500 e-mails.

Discussing the findings of this exercise he said that competition is not always bad and that it is clear that people want choice and control over which professional or profession sees them and where they are seen. And, though the values of the NHS constitution shone through all his consultations, there was a tendency for him only to hear about people in hospitals – a phenomenon of obvious concern to clinical psychologists. He also emphasised the need for strong clinical leadership and that this leadership must include psychologists.

He identified a number of themes that will be of importance to the future development of the NHS. These included:

- Integration: services must be integrated around the patient in every way – The King's Fund will be publishing a paper on this.
- Public health: this must be at the centre of the NHS , with every contact providing an opportunity to talk about public health. This might include psychologists talking about physical health too.
- Information: More data must be published so that people know when a service is good and so that they are empowered by having external access to their own NHS records.

He also talked about the need for education and training, with employers having more say in the design of the local workforce; and about the need for local variation and innovation. He urged psychologists to get involved in all these developments, both nationally and locally.

The symposium ended with a lively session of questions in which the other symposium participants took part. They were Dr Kieron Murphy, Director of the NHS Joint Commissioning Panel , Dr Jane Povey, Clinical Engagement Director with the NHS Commissioning Development Transition Team, and Dr Claire Maguire, a commissioner and Consultant Clinical Psychologist.

Thank you!

We would like to say a big 'thank you' to Paul Britton who has donated several issues of CPF's predecessor, the *DCP Newsletter* to the Society's collection.

We are looking to put all issues of the *DCP Newsletter* online but we are still missing several issues. If you think you can help, please see page 17 for further details.

Notes from the Chair

FIRST, a thank you to all those responsible for our extremely successful annual conference in Birmingham last week. – thanks to much hard work by Dr Jen Unwin, Reshma Oza from the BPS offices, and the conference committee. For the first time we opened the conference with a free public lecture on the topic of sleep, by Professor Colin Espie of the University of Glasgow. This attracted not only psychologists but a good number of A level students and members of the public, thanks to the extensive publicity organised by press officer Jonathan Calder. The theme of sleep was developed further the next day, with a very enlightening overview by Professor Allison Harvey from the University of California. Clearly the idea of an opening, public lecture on a topic that crosses specialties and appeals to the general public is one we should pursue.

Other keynote speeches were given by Professor Max Birchwood on early intervention with young people; Professor Barbara Wilson's overview of neuropsychological rehabilitation; Dr Carol Goodheart, President of the APA, on new designs for psychology practice; and Professor Chris Eccleston on chronic pain. Highlights from the conference were broadcast by Twitter throughout the day via @DCPInfo. The conference concluded, late on the Friday afternoon, with an overview of the new commissioning landscape, featuring Professor Steve Field (the former president of the Royal College of GPs brought in by David Cameron to lead the 'pause' or 'listening exercise' during the passage of the Health and Social Care Bill (whose discussion of the potentially controversial issue of choice in healthcare included the quote that… 'you could choose to take antidepressants that poison your brain, or you could choose to see someone who will actually help you – a clinical psychologist'). Copies of presentations and other materials used during the conference will, I am told, be available soon on the DCP conference website www.dcp-conference.co.uk.

On another subject, some of you will know that there is growing disquiet about the forthcoming edition of DSM-V, due in 2012, for reasons including the expansion of diagnostic categories (e.g. 'attenuated psychosis syndrome'); the proposal for dubious new diagnoses (e.g. 'apathy syndrome'; 'parental alienation disorder'); and the increased emphasis on biological theory along with reduced acknowledgement of sociocultural contexts and causal factors. The Society, along with other organisations, was consulted on the proposed revisions and the response expressed serious reservations about these developments. This inspired one of the divisions of the American Psychological Association, the Society for Humanistic Psychology, to write an open letter to the DSM committee summarising their concerns and requesting a scientific review of the document and its revisions. The Society for Humanistic Psychology has set up a coalition of organisations who endorse this request, and about 40 have now signed up, including our American counterparts APA Division 12 (the Division of Clinical Psychology). In addition, nearly 8000 individuals have also signed the petition.

The Society is currently discussing how we should work with the American Psychological Association (as both the BPS and APA are, in effect, the 'federal' authorities for semi-autonomous divisions) to respond authoritatively and collectively to the invitation to join the coalition. In the meantime, Division members can sign up as individuals if they wish. Please note that this would not imply a particular position about the use of psychiatric diagnosis in general; it is simply a way of registering specific concerns about developments that are not strongly evidence-based and that have potentially damaging implications for vulnerable individuals and groups. See the open letter and the petition www.ipetitions.com/petition/dsm5.

On a similar vein, please note that the Good Practice Guidelines on Psychological Formulation (lead author Lucy Johnstone;

co-authors Stuart Whomsley, Samantha Cole and Nick Oliver) have now been launched and are available as a free download to DCP members from the BPS Shop www.bpsshop.org.uk/Good-Practice-Guidelines-on-the-use-of-psychological-for-mulation-P1653.aspx. We hope they will be an important and useful resource in ensuring best practice in one of the profession's core skills.

Finally… I have decided to step down as DCP Chair and take up the role of 'past chair' with immediate effect – two years early. I'm sorry about that, I know it's not what you voted for. But I think that it was necessary for me to make that decision. The role of DCP Chair is 'officially' two and a half days a week. I had arrogantly assumed that this was a notional commitment, and that I would be able to combine the role with my normal salaried job. But I was finding that commitment increasingly difficult, and I am afraid that the DCP duties – most particularly the communication of strategic decisions amongst the people who needed to know and act – were suffering. As we look forward to the new commissioning arrangements, and in particular the urgent and significant need to engage with local commissioning groups and health and well-being boards, that coordinating role is going to be increasingly important. While I do (perhaps still arrogantly) feel I can articulate a vision and purpose for clinical psychology in the modern world, I feel that: (a) I can continue to articulate that vision, and

(b) we need more than envisioning; we need coordinated action on the ground to make that vision a reality. In trying to keep up with two full-time jobs, I fear that my wellbeing was suffering. I actually do believe what I promote – I think a man whose well-being is at threat is less efficient in his role, and it is wrong, even foolish, to continue. I was not – I'm sorry – prepared to put my academic career further at threat, and I believe the decision I have taken is the right one, for now.

The DCP has asked Jenny Taylor to act as acting Chair until we advertise for a replacement (which I hope will happen swiftly), and I will now take on the role of 'past chair'. As I say, I hope I will be permitted still to articulate a vision and purpose for clinical psychology in the modern world, and that might involve remaining in contact with DCP members… but in a slightly different capacity!
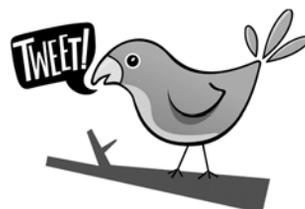
Peter Kinderman
DCP Past Chair

This article was originally circulated as the Chair's piece in the DCP e-mail announcement list.

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Find us at:
www.twitter.com/DCPinfo

DCP Update

Membership Services Unit (MSU) update
Thank you to Graham Turpin (Co-ordinating Editor) and Hessel Willemsen (DCP Update Editor) for providing me with this early opportunity to contribute to the regular DCP Update feature. With members at the centre of the DCP, it feels essential to begin with Membership Services.

- *What does the DCP do for me?*
- *Do I have to be a member of the DCP now that I also have to pay to be registered by the HPC?*
- *Why do I have to be a member of the BPS in order to be a member of the DCP?*
- *The Faculty provides me with good services and is relevant to my job, but is the DCP?*

Many members within the DCP have asked these questions and our curiosity has driven us to seek roles within the Division. I hope this update will attempt to respond to some of these questions and clarify some of the actions and plans for Membership Services.

The MSU, as part of the DCP Executive Committee, is aware of the issues regarding:
1. The need for low cost and accessible CPD.
2. The need for support in conducting .and showcasing psychological research.
3. Promoting the work of the Division.
4. The website!
5. Additional activities.

These issues were the main focus of the DCP's MSU-specific strategic objectives during 2011.

1. Low cost and accessible CPD
- Approximately 20 events took place (some through Branches and Faculties), across different locations, and the recommendation was that prices remained at £25+VAT for DCP members.
- A monthly list of CPD events was e-mailed to all members.
- Relaunch events for non-active Branches were organised.

- A commitment was made to continue to circulate the Conference around different geographical locations (Manchester in 2010, Birmingham in 2011 and Oxford in 2012).

2. Support for members in carrying out and showcasing psychological research
- A research noticeboard was created on the DCP website.
- Access to online journals was improved.
- Members (especially trainees) were encouraged to showcase research at the Annual Conference.
- A CPD research event was organised for early 2012.

3. Promoting the work of the Division
The DCP stand has been used to exhibit and promote the work of the Division to external organisations and to the general public. As low-cost CPD events are also open to non-Society members, this provides the opportunity to demonstrate to non-psychologists the contribution that clinical psychology is able to make as a profession.

4. The website
This remains an ongoing and frustrating issue over which we have little control; however, we will continue in our efforts, and have attempted some limited improvements:
- Events are advertised through the website.
- The DCP webpages have been simplified.
- The new Society's website has been launched and we are awaiting changes to the DCP website.

5. Additional membership services
- Recently there has been a reduction in the number of queries from members, and it is hoped that the FAQ section on the website may have reduced this need. If you have a question about the profession or issues within your local NHS service, try checking out the DCP

FAQ pages (http://dcp.bps.org.uk /dcp/members-area).

■ The MSU committee (in various forms – largely as sub-groups) has continued to meet and includes membership from the Branches, Faculties, Groups, Nations and Service Areas and the Service User and Carer Liaison Committee (SUCLC). The purpose of these meetings and teleconferences is to attempt to represent different groups of members and plan for membership services improvements. It also liaises closely with the Editorial Collective for *Clinical Psychology Forum.*

■ The DCP was promoted at relevant conferences (e.g. the BPS Conference and the BABCP Conference).

■ Liaison has continued with other Divisions of the Society in order to further plan co-working and joint events for 2012 and 2013.

Plans for 2012 and beyond
Joint working
Working more closely with the Branches, Faculties, Groups, Nations and Service Areas, particularly with regards to providing equitable, high quality, relevant and accessible CPD, was seen a priority for the MSU for 2012 and 2013. A different focus for MSU events would then allow improved co-ordination with documents being published by the Division's Professional Governance Panel (PGP) and articles appearing in Clinical Psychology Forum (CPF). Joint working proposals include:

■ Branches, Faculties, Groups, Nations and Service Areas being encouraged to request support from the MSU when organising events (with the aim of improving the access to local and relevant events and also to assist with building the smaller Branches).

■ Further cross-divisional events (with other Divisions of the Society) to be arranged to prevent duplication. The BPS Learning Centre Catalogue lists the CPD events that are being organised through them for 2012 – some are jointly organised between the DCP and the Division of Counselling Psychology (DCoP).

Events
The MSU events that have already been organised for 2012 have been advertised in the BPS Learning Centre catalogue and on the website.

■ Monthly MSU events to be organised through the BPS Learning Centre in various locations, remaining at £25+VAT for DCP members, for DCP events. (Please note, the events that have been organised jointly with DCoP are set at a higher price, at a mid-point between DCP and DCoP usual prices. As DCoP charge more for their events, this issue will require further planning.)

■ All CPD events to be advertised through the website (regardless of whether they are organised by the BPS Learning Centre).

■ MSU events to focus on general interest topics, such as leadership and mentorship, and to link with documents being published by the Society through the DCP's PGP and articles appearing in CPF.

■ High profile speakers are to be increasingly approached for events.

Annual Conference
It was proposed that the Annual Conference should become more accessible, and widen its audience. A one day, cross-cutting themed event is being planned, with broad appeal, to be charged at a small nominal fee (or free, if possible) to take place prior to the 2012 Annual Conference. With the development of the five service areas, it was also proposed that future conferences be linked with one of the five service areas in order to promote better equity. PSIGE is due to take the lead in linking with the Annual Conference Committee for 2012.

Research
Supporting and promoting research is to remain an ongoing objective for the MSU.

■ More CPD events to take place with research as a theme.

■ Further use of the research noticeboard is being encouraged.

■ Branches, Faculties, Groups, Nations

and Service Areas are being encouraged to request support from the MSU when facilitating members' research development.

Mentorship Scheme

The establishment of a mentorship scheme by the Division was considered during 2011. As there are many mentorship schemes already in existence, the Division's role may be better placed as a supportive one, which could include providing relevant training and CPD events, should this be considered beneficial.

Additional membership services

The following improvements to other member services are planned for 2012:
- Changes to *Clinical Psychology Forum*, with the new version being launched at the 2012 Annual Conference.
- The website review is to be placed higher up the DCP's agenda.

- MSU updates to be provided on the website.
- A membership survey to be conducted.

With regards to the questions posed at the beginning, I hope this update has clarified some of the work that is being undertaken by just one of the DCP's Units. The MSU is keen to increase its awareness of members' needs and issues, however, I have been reluctant to contact members on a regular basis with updates and questions due to members' workload demands. Instead, MSU updates will now be provided on the website for information. Any ideas on how to improve what is already being developed and any suggestions for new developments would be very welcome. My e-mail address is dcpmsudirector@bps.org.uk and I look forward to hearing from you.

Petra Gwilliam
Membership Services Unit Director

Race and Culture Faculty Annual Conference & AGM

Black Minority Ethnic (BME) Service Users:

'Driving Service Development'

Friday 17 February 2012, 9:30am – 4:30pm

BPS London Office, 30 Tabernacle Street, EC2A 4UE

Psychologists working in both child and adult services, together with service users, will share examples of best practice where they have worked alongside each other and delivered innovative psychologically based projects.

Presentations by Service Users and
Premila Trivedi Service User Trainer & Adviser
& Kamel Chahal Clinical Psychologist (Adults) & Chair of Faculty
Iyabo Fatimilehin Consultant Clinical Psychologist (Child)
Angela Byrne Clinical Psychologist (Adults)
Saima Masud Clinical Psychologist (Adults)
Dilanthi Weerasinghe Principal Educational Psychologist (Child)
(To be confirmed)

To book http://raceandculture.bps.org.uk/

Books Reviews on the Web

You can find book reviews on the *Clinical Psychology Forum* web pages, including Janie Applebee's review of *Early intervention and autism: Real-life questions, real-life answers*, by James Ball (Future Horizons, Inc., 2008).

This book is specifically aimed at helping parents on their journey from an early diagnosis of autism through providing the information they need to understand autism, laying the foundations for future good behaviour; and then problem solving.

Interested in reviewing a book for Clinical Psychology Forum?

The site also contains the list of books available for review. Please contact Sue Maskrey (s.j.maskrey@sheffield.ac.uk) for further details.

www.bps.org.uk/cpfbooks

Correspondence

Getting into a collective fix over diagnosis
The careful appraisal of the collective fix we are in about diagnosis from Mike Berger (CPF, 228) invites a formulation about why collectively we have still not rejected diagnosis in favour of formulation at all times and in all circumstances (Pilgrim, 2007). In the media column of the same issue, Lucy Johnstone complains that we have a press in which 'diagnostic labels are accepted as statements of fact'. But our profession in part glibly makes the same error. Without that overlap of error, some of us would not need to keep re-stating our critiques to our own colleagues.

The following factors are relevant to build up a formulation of our failure of collective will to put that repetitive pattern in the dustbin of history. First, undergraduate textbooks, written for and by psychologists, repeat the reifications of DSM and ICD (and then may or may not offer critiques of them). The behavioural checklist and aetiological neutrality approach of DSM-IV is particularly seductive for psychologists, as a shared starting point for discussing psychological difference in society. But beware DSM-V (2013), in which the etiological assumptions of brain disorder are going to return with a vengeance.

Second, postgraduate psychologists gain research grants that investigate diagnostic-related groups (DRGs). Privately they may be embarrassed by studying CBT 'for anxiety disorders/schizophrenia/ borderline personality disorder/depression (fill in the whole series of medical reifications on grant proposals and published papers by psychologists)'. However, their academic careers and mortgages may rely on playing the medical game. Similarly, insurance based systems in countries like Australia and the US require diagnostic box ticking for psychologists to be paid. (Berger explains the creep of this box ticking in the NHS for other technocratic reasons.) In these ways psychologists contribute to a discourse of legitimacy about psychiatric diagnosis.

Third, an investment in particular models of therapy seduces researchers and practitioners into the dubious logic of RCTs. The latter create a questionable logical equivalence between drugs and types of psychological therapy. This then bolsters the logic of NICE (a named fix for a named problem). To keep this cognitive distortion in play clinical psychologists, who are the beneficiaries of the medical game, become wilfully blind (Heffernan, 2010) to the blindingly obvious: personal change is largely a function of compassionate care in which good working alliances emerge independent of models deployed (Lambert, 2007). This is what we should be focusing on in our work, not our obsession with 'treating' 'anxiety disorders' 'with' (fill in your preferred model of therapy here). We could just park our preferred models in a period of reflection. Instead we could think about improving our chances of providing good working alliances in our services and reducing our risk of malign ones that feed professional neglect and abuse. This quality control point should appeal to service managers, not just practitioners.

Fourth, we could collectively confess that human science is inherently irresolvable in many ways and the rhetoric of linear scientific incrementalism is a deception both to ourselves and others. British

empiricism is partly responsible for this deception but is not the only cultural challenge we face about naïve realism, within our variegated body of psychological knowledge. We cannot find a stable consensus on what exists, what form of knowledge is legitimate and what set of methods to privilege (Foucault, 1973).

Given these four groups of factors, we could try to be collectively honest about finding ways of agreeing on a few basic points. We could focus on: common factors in change, not models; the current and historical factors involved in a person's life that might render their behaviour and experience intelligible and change possible; and the hidden hand of the drug companies and other material forces in shaping a DRG obsession in health policy and healthcare commissioning. Applied psychology is embedded in a political economy, and working out how that ticks might be the start of escaping from the fix that Mike Berger highlights.

The struggle continues but we have to put our own house in order. We cannot keep blaming the mass media and psychiatrists, the better ones of whom are more insightful about the daftness of de-contextualised categorical reasoning, than many naïve realists within our own ranks, who hang on to labels like 'PTSD' (Young, 1995; Summerfield, 1999).

David Pilgrim
Professor of Mental Health Policy, University of Central Lancashire; dpilgrim@uclan.ac.uk

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From the Editor's chair

FEBRUARY STARTS with a Special Issue around diversity compiled by the University of Lancashire training course. Although its focus is around training and has many excellent suggestions as to how DClinPsy courses might wish to progress the 'diversity agenda'; I am sure that the literature reviewed will also be of interest and use for practitioners and services. Although we are all aware that the 'equalities agenda' or 'diversity' (as trainers have usually referred to these issues) has recently been reasonably profiled within the training community; it has tended to concentrate on issues of race and culture, especially in relation to BME communities. This Special Issue appropriately and helpfully extends our understanding and embraces further equalities issues such as spirituality and religion; and lesbian, gay and bisexual clients; social class – in addition to cultural competence and working with people from different cultures to our own, especially from BME communities. We are, therefore, very grateful to Anna Daiches and Ian Smith for bringing this Special Issue together, the contributing authors from the University of Lancaster, and to Garfield Harmon and Jane Vinnicombe from the *Clinical Psychology Forum* editorial collective for helping to edit the final version.

In addition to the papers included within the Special Issue, we have also chosen to publish two articles from our usual publication queue which we hope will be of relevance. The first is also from the University of Lancaster course and is a report by Katie Slevins and Anna Daiches on the challenges of offering consultancy into an orphanage in Cambodia. Having just returned from Bangladesh recently, I can very much identify with the difficult task of unpicking and navigating the cultural challenges of imparting advice and knowledge from one culture to another, especially when you are seen as an expert in the field, despite one's deep ignorance of their home culture. Lastly, we have a reflective piece from a group of trainees at the University of Surrey discussing their experiences of a reflective practice group, and in particular focusing on the diversity and differences within the group.

We have some regular features including a final 'Chair's column' from Peter Kinderman who has announced that he is reluctantly having to step down as DCP Chair. Personally, I would like to thank Peter for his tremendous energy and contributions to the DCP these last 12 months. We also have Lucy Johnstone's Media column, DCP Update and continuing lively correspondence around 'diagnosis'. In addition, we have some book reviews, which are very much down to the sterling efforts of Stewart Grant and Tony Wainwright who have revived the Book Reviews Column. We chose to publish some reviews within this issue of *Clinical Psychology Forum* but want to stress that there are many more reviews available on the Clinical Psychology Forum website (www.www.bps.org.uk/cpf).

Finally, the editorial collective had a face-to-face meeting at the DCP Annual Conference where we reviewed our annual report available on the *Clinical Psychology Forum* web page, plus plans for a revised *Clinical Psychology Forum* that we wish to work on over the next few months. Essentially, this consists of more commissioned columns from the Pre-qualification Group and also the Service Users and Carers Liaison Committee. We also thanked Jonathan Calder for his contributions to Clinical Psychology Forum over the last decade and thanked Mark Wellington who has taken over from Jonathan as ensuring a successful and smooth transition. In addition to the annual report, we have also revised the Guidance for Contributors and the FAQs which are all available from the website, and essential reading for anyone wanting to submit their work to Clinical Psychology Forum.

Graham Turpin
Co-ordinating Editor

Annual Conference 2012

The British Psychological Society

Language and communication using all the senses

The psychology of participation in sport and exercise

18–20 April
Grand Connaught Rooms
London

Call for submissions

Psychology for the public and private sectors

The psychology of violence and conflict

www.bps.org.uk/ac2012

Media Column

DCP Annual Conference

By the time you read this, 2011 will be over, but the DCP can look back on a very successful end to the year at the Annual Conference in Birmingham in December. The stimulating programme started with talks by international experts on a topic of interest across specialties: sleep and sleep disorders. Professor Colin Espie's opening speech on this topic resulted in an article on the Boots health advice website (tinyurl.com/sleep-essential).

It was my first experience of how social media such as Twitter allow us to play an increasingly active role in creating our own publicity. Society Press Officer Jonathan Calder and I were between us able to tweet moment-by-moment highlights from the main speeches via @DCPInfo, concisely summarised into 140-character soundbites. A couple of topics were picked up by journalists. There is an art to writing a press release with an eye-catching heading that has popular appeal. One successful example was 'Phone for psychological help while waiting for a bus.' This described the Glasgow STEPS mental health project's latest development – a phoneline service that allows people to speak to a therapist at a time and place convenient for them. It was publicised on the BBC News website (www.bbc.co.uk/news/health-15987123) Headlines that did not catch journalists' eyes, but can still be read on the Society's webpage, are: 'Helping patients work out what is real' (www.bps.org.uk/news/helping-patients-work-out-what-real) and 'Imaginary friends can help with trauma' (www.bps.org.uk/news/imaginary-friends-can-help-trauma).

Media coverage of Rethink's new campaign

The mental health charity Rethink's launch of a commission into 'schizophrenia', to mark the 100th anniversary of Bleuler's coining of the name (tinyurl.com/rethink-schizophrenia), received media coverage on BBC Radio 4 and in online articles for *The Independent* and *The Guardian*. In last month's column I discussed the media's 'complete failure to question the terms and assumptions of its coverage of mental health issues. Medical model language like "illness" is universally employed, diagnostic labels are accepted as statements of fact.' Alas, these faults were all on display in an article from *The Times* ('We've named schizophrenia – Now let's treat it', 4 November).

The journalist, Philip Collins, rightly noted the 'astonishing and shaming fact' that the developed world actually has worse outcomes for serious mental problems than developing countries. He also cited Richard Bentall's book 'Doctoring the mind' (Allen Lane, 2009) to the effect that 'the success rate of drug-based psychiatry in treating serious psychoses [is] not much better than the old astrologers and apothecaries.' All very well-intentioned, but Collins has seriously misunderstood one of the central arguments of the book. The article's heading, 'We've named schizophrenia. Now let's treat it' and the numerous references to the 'schizophrenics' whom we are failing to help, make a very curious conjunction with sentences like: 'There is nothing technical about a lot of mental health services and they would be better provided by former patients and your peers than by doctors and nurses… Instead we put people into diagnostic groups.' Well yes, and the lack of validity of these diagnostic groups has been a theme of the work of Richard Bentall and others for many years – so why use them so liberally in an article that seems to fancy itself as challenging the orthodoxy? Sorry, but if this had been a trainee essay I would have sent it back with 'Muddled thinking! Please re-submit!' on the marksheet.

On that rather irritable note, I would like to suggest a New Year's resolution for anyone who hasn't already joined the Society's database of experts who are willing to be contacted by the media: please e-mail presscentre@bps.org.uk to volunteer. We will only be able to raise the quality of public debate if we are willing to contribute to it. Clinical psychologists' voices are still too rarely heard.

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Guest Editorial

Diversity and clinical psychology training

Anna Daiches & Ian Smith

F OR A PROFESSION that claims to be based upon a philosophy of respect for individual differences (DCP, 2010) clinical psychology seems surprisingly poor at encompassing and dealing with difference and diversity. This is reflected not only in continued difficulties in recruiting a diverse workforce to the profession (Turpin & Coleman, 2010), but also in frequently employed assumptions that diversity is something 'other' from 'us' practitioners (see Daiches & Golding (2005) for a brief discussion, and Adetimole, Afuape & Vara (2005) for a first-hand account).

Perhaps even the term 'diversity' should be treated with suspicion. Patel (2010) argues that 'diversity has become a "catch all" phrase used in clinical psychology to privilege certain understandings… and minimising the more unpalatable task of naming and addressing racism and its impact on wellbeing'. Whilst this may certainly be true in many situations, we believe that there is value in considering the common issues relating to different kinds of diversity, *provided this is done with a clear recognition of the role of power in relation to such differences.* The cultural empathy model (see Gurpinar-Morgan, this issue) is aimed at promoting more generic skills in working with people from different cultures. In the same way, we hope that promoting the recognition and understanding the impact of discrimination in our society relating to race, culture, gender, sexual orientation, social class and other differences will help practitioners develop more generic skills in dealing with difference.

There is little doubt that professional training programmes in clinical psychology have struggled in finding ways to address diversity issues in the curriculum. The approach at Lancaster, for example, has oscillated over the years. Once upon a time the curriculum included dedicated 'diversity teaching', predominantly conducted by people who identified themselves as being from 'diverse' (i.e. non-'white heterosexual middle class') groups. This approach came to be viewed as tokenistic, and so specific teaching on 'diversity' was abolished and instead all teachers were asked to account for how they addressed issues of diversity in their teaching. More recently this approach has in turn been recognised as ineffective, primarily because (as is identified in a number of the contributions in this special issue) many qualified clinical psychologists lack confidence and skills themselves in addressing issues of diversity. Our current position is one of exploring ways to take positive action to help and encourage all teachers for the programme to consider diversity as a core element of the teaching, no matter the topic. However, at the same time we are experimenting with ways of delivering dedicated teaching relating to diversity issues in the broadest sense. The papers in this issue are one of the fruits of this endeavour – each is based upon a presentation by a trainee at a half day 'mini-conference' we held last autumn, which in turn is based upon a piece of academic coursework.

In this special issue, we aim to look in a very practical sense at what should and could be done in training clinical psychologists to improve practitioners' awareness and skills in asking about and dealing with diversity of all kinds. We are strongly of the view that an essential starting point to developing skills in this area is an awareness of the diversity within ourselves and our peers, as opposed to identifying diver-

sity is something 'other' or 'out there'. The authors of the papers in this issue wrote on their respective topics because they felt moved to do so through their experiences. Our aim in presenting these papers is to promote both personal reflection in readers, and to put forward for discussion some thoughts about how diversity and difference can be meaningfully addressed within clinical psychology training.

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To what extent are UK clinical psychologists adequately trained to work confidently and effectively with lesbian, gay or bisexual clients?

Deborah Anderson

How to develop clinical psychologists' confidence and effectiveness in working with lesbian, gay and bisexual (LGB) clients is considered in light of evidence that doctoral training programmes do not appear to be adequately facilitating learning in this area.

APPROXIMATELY six per cent of UK residents identify as lesbian, gay or bisexual (LGB) (Campbell, 2005) and have been found to experience higher rates of mental health difficulties and access mental health services more frequently compared to their heterosexual counterparts (King et al., 2008; King et al., 2003). With this in mind, it is vital to consider how confident and skilled clinical psychologists feel in working with LGB clients. This in turn involves consideration for how well UK-based clinical psychology doctoral training (CPDT) programmes are addressing the training needs of clinical psychologists in this area.

Clinical psychologists are expected to meet standards of proficiency within their professional role as set out by both the Health Professions Council (HPC) and the British Psychological Society. Of relevance to working with LGB clients, these standards require clinical psychologists to 'understand the impact of differences such as gender, sexuality… on psychological wellbeing or behaviour' (Health Professions Council, 2009a, p.29) and to practise 'within the recognised limits of their knowledge, skill, training, education and experience' (British Psychological Society, 2006a, p.14). Furthermore, the HPC directs clinical psychology doctoral training (CPDT) programmes to follow relevant guidance to ensure that adequate training is provided in specific areas to meet these standards. For example, the Society's Faculty for Sexual Health and HIV has produced 'good practice' guidelines for the training of clinical psychologists in sexual health, which identifies important competencies such as developing the ability to 'be aware of the range of expressions of human sexuality which may be different and unfamiliar to a trainee and be able to reflect on their attitudes and feelings this may evoke' (British Psychological Society, 2006b, p.8).

Current research suggests that CPDT courses may not be meeting the standards required to allow clinical psychologists to develop both confidence and skill in working effectively with LGB clients. Shaw, Butler and Marriot (2008) reported on findings from a survey of 23 UK-based CPDT courses regarding their provision of training in issues of sex and sexuality. Findings demonstrated that the provision of training varied widely across courses and was lacking in many specific areas. Only 57 per cent of respondent programmes reported assigning between more than two hours over three years for trainees to learn specifically about working with LGB clients, and only 48 per cent facilitated between one and three hours for trainees to reflect on their beliefs and assumptions around LGB issues. As Society good practice guidelines acknowledge (British Psychological Society, 2006b), CPDT can never aspire to equip all trainees with the full range of necessary skills and

knowledge to work competently with all kinds of clients. However, evidence related to the experiences of clinical psychologists suggest that a basic grounding in working with LGB clients is necessary to increase trainees' confidence and skills and to provide an opportunity to develop self-awareness of knowledge, beliefs and assumptions around LGB people and lifestyles.

Clinical psychologists work within mental health frameworks which have only relatively recently acknowledged that homosexuality is not a mental health disorder in itself (DSM-II, American Psychiatric Association, 1968; ICD-10, World Health Organisation, 1992). Despite changes, there is some evidence that the assumption of heterosexuality and the stigmatisation of non-heterosexuality still pervades within both academic and professional psychology. For example, content analysis studies on UK psychology textbooks have identified a lack of integration of LGB identities (Barker, 2007) and LGB students still regularly experience exclusion and estrangement within UK undergraduate psychology courses (Hodges & Pearson, 2008). Furthermore, the Society itself experienced internal conflict, objection and the expression of negative attitudes in public forums during the establishment of the Lesbian and Gay Psychology Section (now the Psychology of Sexualities Section) in 1998 (Kitzinger & Coyle , 2002).

On an individual level it would be unrealistic and neglectful of individual difference to assume that clinical psychologists do not hold a similar range of positive and negative opinions towards LGB people as seen in the general population. Indeed, a large-scale survey of adults in the UK reported that a quarter of people still held a significantly low opinion of lesbians and gay men (Cowen, 2007). Additionally, findings suggest that many heterosexual clinical psychologists experience awkwardness about finding the right language with which to discuss LGB issues with clients which leads them to shy away from these issues (Snowdon-Carr, 2005). Furthermore, the same study also reported that clinical psychologists often have a lack of general knowledge

of where information and support can be accessed for both LGB people and the clinical psychologists working with them.

Indeed, it appears common for LGB clients working with clinical psychologists and other mental health workers to have concerns about the 'safety' of disclosing their sexual orientation within mental health settings (Robertson, 1998). Furthermore, a number of unhelpful experiences have been found to offend and often silence LGB clients within their therapeutic encounters and therefore reduce the usefulness of psychological interventions. Some of these unhelpful experiences have been identified as when the therapist; assumes that the client is heterosexual (Annesley & Coyle, 1998); lacks knowledge of how the experiences of LGB clients can be different to those of heterosexual people (Malley & Tasker, 2007); and avoids discussing sex and sexuality with clients at all (Malley & Tasker, 2007).

Whilst further up-to-date research clearly needs to be carried out in all of these areas of discussion, the current available evidence certainly suggests that CPDT courses may not be reaching the standards required of them in this area and that the content and delivery of training around sexual orientation should be reviewed and revised accordingly. If CPDT is not adequately preparing clinical psychologists to work confidently or effectively with LGB clients, this in turn could be having a negative impact on the experiences of LGB clients in receiving effective help from mental health services. On a more positive note, conferences and other continuing professional development events over the past decade which have been organised by both the Division's Faculty for Sexual Health and HIV, and the Society's Psychology of Sexualities Section have moved things forward and are likely to continue to do so. Indeed, these events have often promoted discussion around the best ways to incorporate LGB issues into CPDT (Butler & Shaw, 2007). In addition, the Society has provided guidelines for CPDT courses on how best to prepare clinical psychologists to be able to

work competently with LGB clients (British psychological Society, 2006b).

A personal perspective on working with gay clients was put forward by Acaroni (2006) during a discussion on how difficulties in working with LGB clients could be associated with clinical psychologists adopting 'four dangerous assumptions'. This discussion demonstrated some of the questions that could be asked during CPDT to allow clinical psychologists to reflect on where they sit in relation to these assumptions and consider how they aim to prepare themselves for future work with LGB clients. The first two assumptions were related to the amount of knowledge derived from training. Firstly, Acaroni suggested that to assume that CPDT alone provides enough knowledge about working with LGB clients can stop clinical psychologists questioning their competency in this area. Alternatively, to assume that nothing from general psychological knowledge can be applied to working with LGB people can negate the majority of training received that is relevant to all individuals regardless of sexual orientation. The remaining dangerous assumptions were related to the amount of personal experience clinical psychologists have. Acaroni also suggested that those with personal knowledge of LGB issues can be in danger of assuming that being LGB is 'not an issue' and that 'everyone is the same' which risks missing the important differences that exist between heterosexual and LGB experiences such as the experience of 'coming out' as LGB in a predominantly heterosexual society. Alternatively, he also suggested that to assume that one has no knowledge of how LGB people live their lives risks neglecting the shared human experiences applicable to all people.

Certainly individual clinical psychologists should recognise the importance of self-reflection around their assumptions, attitudes, and level of competence in this area and seek out further training or information as appropriate. In the US the 'guidelines for psychotherapy with lesbian, gay, and bisexual clients' (American Psychological Association, 2000) have been developed due to concerns that psychologists qualifying from US-based CPDT courses were not doing so with sufficient knowledge of LGB issues. These guidelines provide psychologists with basic information on LGB issues and guide them towards relevant resources for continuing professional development. Similar guidelines have not yet been produced in the UK, perhaps because it has yet to be acknowledged that UK clinical psychologists are in a similar position upon qualification. Hopefully this discussion can generate further reflection and consideration into this topic and direct both clinical psychologists and those involved in the delivery of CPDT towards the relevant recommendations, standards, guidelines and resources that will allow them to continue to improve both confidence and competence.

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Your help needed!

Readers with long memories may remember *CPF's* predecessor, the *DCP Newsletter.*

The Society is hoping to make all issues of *DCP Newsletter* available online, free for members to download. Unfortunately, we do not hold issues 1–12 or 23 of the *Newsletter*, so if you have any of these lying about on your bookshelf or in your attic and would like to help, please get in touch.

Regrettably, we will not be able to return your original hard copies, but by donating them you will be helping to make them available in electronic format for posterity and as a potentially valuable resources for other psychologists.

If you think you can help, please contact Mark Wellington at the Society's Leicester office (tel: 0116 252 9589; e-mail: mark.wellington@bps.org.uk).

The place of religious and spiritual beliefs in therapy

Catherine Cooper

This paper explores the place of religious/spiritual ideas in therapy. It reviews research regarding how to integrate beliefs at the level of service access, assessment and intervention. The wider contexts of professional guidelines and clinical psychology training are examined.

RELIGION and the clinical practice of psychology can be viewed as inherently linked due to their vested interests generally in wellbeing, and specifically in working with people to realise the lives to which they aspire (Myers, 2004). Many psychotherapeutic traditions emphasise the importance of completing a full assessment with potential clients to allow the therapeutic process to move forward to a helpful, relevant and sensitive formulation of the current situation and difficulties (e.g. Carr & McNulty, 2006, Chapter 3 [CBT]; Dallos & Stedmon, 2006, Chapter 4 [systemic]). It can be argued that in any formulation-driven approach, a client's religious and spiritual contexts are vital components for clinicians to at least consider before moving forward to intervention (Frazier & Hansen, 2009). As such, it is important to explore how clinicians should consider raising the issue of religious and spiritual beliefs within the assessment and formulation period. In this paper I will consider this issue through an examination of literature that explicitly tackles the place of religious and spiritual beliefs in therapy. However, it is recognised that there are also many developments in secular therapy modes that use some of the philosophical ideas and techniques of religions (such as the Buddhist ideas present in mindfulness therapies) that may be relevant to this issue, but fall beyond the scope of this paper.

Broader context of religious or spiritual beliefs in clinical psychology

Before exploring the arguments at the centre of this discussion, it is key to briefly mention the context of these ideas in terms of religiosity within populations of clinical psychologists and the approach taken by professional and regulatory bodies. Research indicates that religion is an area in which there are discrepancies between the views of the general population and that of clinical psychologists. (Baker and Wang, 2004; Gallup Organisation as cited in Hoge, 1996; Mayers, Leavey, Vallianatou & Barker, 2007; Office of National Statistics, 2004; Shafranske & Malony, 1990). The clinical psychologists sampled (Baker and Wang, 2004; Shafranske & Malony, 1990) described themselves as less religious and stated that religion and spirituality have less impact on their lives than the general population samples.

Furthermore, both the British Psychological Society (BPS) as the voluntary professional body and the Health Professions Council (HPC) as the mandatory, regulatory body for clinical psychologists make mention of religion as an area of diversity that should be attended to (BPS, 2009; HPC, 2008). However, as is to be expected from professional guidelines, no direct recommendations are made as to how to practise in a way that is inclusive with regard to religious diversity. Against this legislative backdrop, it is interesting to consider the training that clinical psychologists receive in terms of religious diversity. It has been argued that there is tension between professional practice guidelines, recommending appropriate inclusion of religious diversity, and the lack of teaching focused upon these issues on clinical psychology training

courses (Plante, 2008). Yarhouse and Fisher (2002) argue that the lack of formal training on this topic may be one of the reasons behind their finding that there was a significant difference between what clinicians believed was valuable in terms of multicultural practice and what they actually managed to introduce into their clinical work.

Working with religious or spiritual beliefs in psychotherapy

When looking generally at how to integrate religious/spiritual ideas into therapy, there appears to be a number of important behaviours and processes to consider. One of the most frequently cited processes appears to be clinicians' self-awareness in terms of their own religious values and beliefs (Aten, Mangis & Campbell, 2010; Lovinger, 1996, Chapter 12; Myers, 2004). In particular, it is argued that it is essential that clinicians work with an awareness of their beliefs so they can process what client beliefs may lead to problems through clashes with the clinician's beliefs or lead to tension between belief systems (Myers, 2004).

The value of working with community spiritual or religious leaders has also been highlighted (Myers, 2004). The value of this appears to be twofold; firstly, contact with religiously influential figures can increase knowledge of psychological interventions within possibly hard to reach communities (Aten et al., 2010). Secondly, it could attenuate the difficulty in traversing the boundaries between serious mental health problems (such as psychosis) and pathologising strongly held religious or spiritual beliefs (Meissner, 1996, Chapter 9; Myers, 2004).

How to introduce and include a client's religious and spiritual beliefs within the therapeutic process

The main focus of the literature regarding when and how to include a client's spiritual context in psychotherapy, has been on the assessment process. Many papers have encouraged clinicians to consider religious/spiritual beliefs and functioning as a core area for initial assessment (Hathaway, Scott & Garver, 2004; Myers, 2004; Sperry, 2003). Proponents of religious/spiritual inclusion contend that alongside the current wealth of information collected during the assessment period, a place should be found to discuss religious and spiritual issues (Hathaway et al., 2004). It could be argued that although religious and spiritual issues are deeply personal matters, the skills that clinicians already demonstrate when addressing sensitive issues early in the therapeutic relationship, could also be used to gain information on religiosity and spirituality.

Accordingly, ideas have been forwarded as to how to include these ideas in assessment – for example, Hathaway et al. (2004) suggest the use of a simple probe such as 'Is religion/spirituality important to you?' during the assessment. However, Myers (2004, p.73) documents a number of essential components of an assessment of religious/spiritual beliefs including affiliation to a formal religion and the beliefs that a client wishes to be taken into account during therapy.

Religiously or spiritually-oriented psychotherapy

Alongside the recent, more general, interest by clinicians and researchers in working with a client's religious and spiritual beliefs, there has also been a more formal movement towards therapeutic approaches that directly work with spiritual beliefs (Martinez, Smith & Barlow, 2007; Smith, Bartz & Richards, 2007; Sperry, 2003). Religiously or spiritually-oriented psychotherapy is described as any therapeutic approach that explicitly addresses issues of spirituality and/or use techniques and methods aligned to specific religious or spiritual groups (Tan, 1996, Chapter 13). The majority of research into religiously or spiritually-oriented approaches does not present these approaches as an independent framework; instead they are cited to be used alongside other major theoretical frameworks such as cognitive-behavioural therapy and psychodynamic approaches (Martinez et al., 2007; Smith et al., 2007).

Tan (1996, Chapter 13) separates religiously integrated practices into those that are implicit and those that are explicit. Implicit practices are those that do not directly use spiritual behaviours but create a respectful, nurturing backdrop against which religious and spiritual ideas can be explored. Explicit practices are more overt, observable and involve the direct use of religious behaviours in the therapeutic process, as well as including structured discussions around beliefs within sessions. However, further exploration is warranted into whether some of these techniques and activities can be helpful both in a religious and in a non-religious setting – for example, Warr, Butcher and Robertson (2004) highlight the benefits of non-religious charitable activities.

The support for spiritual psychotherapy in the literature, alongside the widespread prevalence of religiosity and spirituality, suggest it is pertinent to be able to offer specific services that encompass these ideas. However, alongside this responsibility to provide suitable services, there have been ethical considerations highlighted to consider when undertaking this kind of work. One potential area of concern is the lack of training that the majority of clinical psychologists receive in this area, which may lead clinicians to experience feelings of working outside their competence (Martinez et al., 2007). This is also an issue raised by the HPC (HPC, 2008) and the Society (BPS, 1995) who stipulate that clinicians must work within the limits of their competence and use continuing professional development opportunities to address gaps in competence.

Client's views on including religious and spiritual beliefs in psychotherapy

Although there is only a limited number of papers that research client views on the use of religion/spirituality in therapy (Rose, Westefeld, and Ansley, 2001), valuable insights can be gleaned from these papers. For example, it has been found that clients who hold strong religious/spiritual beliefs may have initial reservations about entering into a secular therapeutic relationship. Nevertheless, they overwhelmingly feel that the therapeutic process is an appropriate place to discuss their spiritual contexts (Martinez et al., 2007; Rose et al., 2001). However, as clients do not always anticipate speaking about matters of a spiritual nature in therapy, a blanket approach to asking about these issues in assessment may not be the most appropriate or sensitive way of introducing this topic of conversation.

To add a further level of complexity to the dilemma of whether or not to include spiritual or religious beliefs in psychotherapy, attention must be drawn not only to those who decide to attend psychology services, but also to those who do not choose to use this service. There are various tensions that may lead those who hold strong religious or spiritual beliefs to avoid psychotherapy: These tensions include seeking help being seen as a lack of belief in a higher power and concern that the traditionally secular practice of psychology will be-little religious/spiritual beliefs (Mayers et al., 2007; Myers, 2004).

Conclusions

Within the framework of the current literature that specifically deals with spiritual ideas in therapy, it would seem that it is just as essential to take a client's religious and spiritual beliefs into account during the therapeutic process as it is any other area of diversity. The literature that has looked into client experience finds that clients feel that therapy is an appropriate place to raise spiritual/religious beliefs or concerns, and furthermore, clients value working therapeutically in the context created by their belief system. However, it also may be the case that because psychology and religious ideas have not always had a complementary relationship, this area of diversity has been underexplored within therapeutic relationships.

Alongside these arguments is the idea that a proportion of the population that hold strong religious beliefs do not feel comfortable accessing psychological thera-

pies (Myers, 2004; Rose et al., 2001). This may mean that clinicians are not being challenged by the whole breadth of diversity in religious and spiritual beliefs. It seems a pressing challenge for clinicians and services to communicate the message that therapy can be a place that respects religious and spiritual ideas and can work within these parameters in a way that is helpful and sensitive.

Before clinicians can be expected to reach out to sceptical communities or integrate spiritual ideas more fully into their practice, the key areas of confidence and competence must be addressed. With most American clinical psychology courses not offering explicit teaching on issues of religious/spiritual diversity (Plante, 2008; Yarhouse & Fisher, 2002) and British practice guidelines (BPS, 1995; HPC, 2008) not referring in any detail to how to work with these differences, it is difficult to identify where clinicians can gain competence in working with these matters. This appears to follow

through to a lack of confidence by qualified clinicians to address spiritual/religious ideas in the therapeutic context (Frazier & Hansen, 2009). Therefore, as the research body demonstrating the importance of religious and spiritual beliefs grows, it will be essential to provide clinicians with the appropriate level of training and reflective space that allows them to work with these ideas effectively.

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What is cultural competence and how might clinical psychology training equip psychologists to work with ethnic diversity?

Ayse Gurpinar-Morgan

Cultural competency training has been suggested as a means of increasing the knowledge and skills of health professionals. This review presents a number of theoretical models of cultural competency which can be drawn upon in the preparation of cultural competency training and a variety of methods of cultural competency training are described.

A NUMBER OF CHANGES in the socio-political and professional contexts within which clinical psychologists work have led to an imperative for the provision of more effective, accessible and acceptable services for ethnically diverse clients (Department of Health, 2005; Yutrzenka, 1995). An increased prevalence of mental health difficulties among some black and minority ethnic (BME) communities in the UK (Hull, Kilbourne, Reece & Husaini, 2008; National Institute for Mental Health in England, 2003) and continuing unmet psychosocial need among some BME groups (Department of Health, 2005; Williams, Turpin & Hardy, 2006) means that mental health services are being urged to provide clinical psychologists who are able to work effectively with ethnic diversity. Clinical psychology doctoral training programmes are therefore considering how best to equip future clinical psychologists to work with clients from diverse ethnic backgrounds. Cultural competency training has emerged as one attempt to increase the skill of the workforce to meet the needs of diverse clients (Betancourt, 2003).

The cultural competency model originated within the USA as a response to the need for health care practitioners to have the skills to work with people from diverse socioethnic groups (Hoge et al., 2005). In the UK, this concept is referred to as 'working with ethnic diversity', reflecting a broader concept of working to understand how a person's (and family's) religious beliefs, race, culture, language, country of origin, country of residence and social or political influences may impact on their wellbeing (Loue, 2006). In this paper, the term 'cultural competency' is used to denote an ability to work with ethnic diversity.

The importance of training in cultural competence

Research suggests that some psychological therapists feel unsure of how, when or why to address ethnicity in the therapeutic relationship (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Maxie, Arnold, & Stephenson, 2006). Research suggests that some clinical psychologists are reluctant to address ethnicity issues such as spiritual or religious beliefs (Crossley & Salter, 2005), race (Knox et al., 2003) or ethnic background (Maxie et al., 2006). Without training in working with ethnic diversity, it is argued that clinical psychologists may continue to rely on the (positive or negative) assumptions, stereotypes and beliefs of their own cultural groups, an approach which has been implicated in the reduced uptake of mental health services among some minority communities (Williams et al., 2006) and may be linked to reduced client ratings of therapist competence (Constantine, 2002).

What constitutes cultural competence?

There are a number of different conceptual models of cultural competency, each based on the assumption that increasing therapists'

abilities to work with ethnically diverse clients will improve therapy outcomes and reduce disparities between the accessibility and effectiveness of health services for minority versus majority populations (Brach & Fraser, 2000). Many of the skills necessary to work with ethnic diversity are similar to those used in therapy with an ethnically similar client (Brown, 2009). A range of additional skills have also been suggested to sustain engagement and facilitate the development and maintenance of a positive therapeutic alliance, resulting in positive outcomes for the ethnically dissimilar client (Lo & Fung, 2003). For instance, the therapist must be skilled in actually addressing ethnicity with the client, in terms of conversations about race, spiritual beliefs, religious practices or cultural background (Chang & Berk, 2009). A therapist cannot hope to comprehensively formulate how a client's ethnic background may be important without gaining information about it (Yarhouse & VanOrman, 1999). When working with clients of multiethnic heritage (for instance with parents from two different ethnic backgrounds), the therapist must be aware of the unique experience of and challenges to developing a multiethnic identity (Pedrotti, Edwards, & Lopez, 2008). It may be important for the therapist to understand how their own background may have influenced the development of stereotypes or prejudices that may become activated in therapy with an ethnically dissimilar client (Brown, 2009). The therapist may need to address the similarities/differences between themselves and an ethnically dissimilar client and attend to any ruptures that an acknowledgement of difference may cause in the alliance (Keenan, Tsang, Bogo, & George, 2005). However, evidence suggests that discussing ethnicity generally leads to a strengthening of the alliance (Knox et al., 2003). Research suggests that clients identify culturally competent therapists as those with a mixture of both generic skills that can be adapted to meet individual needs and knowledge of specific issues such as stigma (related to psychological help-seeking), oppression, discrimination and racism (Chang & Berk, 2009).

Theoretical models of cultural competence

Debates have arisen within the literature about which of the conceptual models offer the most effective means of training mental health professionals to become culturally competent. Some advocate for a cultural attitude model; teaching awareness, knowledge and skills necessary to develop an understanding of the needs of an ethnically diverse client group, rather than focusing on the less tangible concept of competence (Shahnavaz & Ekblad, 2007). Similarly, Dyche and Zayas (2001) advocate that training programmes focus on the development of cross cultural empathy, underpinned by the concepts of receptivity, knowledge and collaboration, and a commitment to career-long self-reflection (Dyche & Zayas, 2001; Tervalon & Murray-Garcia, 1998). The cultural attitude or cultural empathy models provide a framework for training in skills such as how to talk to clients about ethnic (and other) similarities and differences, how to listen out for and encourage client and therapist self-reflection on cultural issues and how to collaboratively conceptualise this information in a meaningful way. The cultural attitude or cultural empathy models are in contrast to the culture-specific model, which dominates in the USA, in which cultural competence is seen as the acquisition of facts or truths about a specific group of people (Brown, 2009). Lastly, social constructionist models emphasise the importance of developing a shared narrative that is co-constructed between the client and therapist to incorporate both of their world views (Brown, 2009; Lakes, Lopez, & Garro, 2006).

There is little primary research evidence that distinguishes between the effectiveness of one model over another (Brach & Fraser, 2000). Most of the literature in this newly emerging area is still theoretical or anecdotal (Brown, 2009), or restricted to case studies or clinical vignettes (Lakes et al., 2006), which may lack ecological validity (Farsimadan, Draghi-Lorenz, & Ellis, 2007). Research with medical students suggested that cultural attitude or empathy-based cur-

riculums led to significant positive shifts in affect among trainees (Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004). Specifically, research suggested trainees enrolled on such curriculums were more likely to recognise the importance of attending to a patient's ethnic background (Crosson et al., 2004; Dogra, 2001). Furthermore, a systematic literature review of the effectiveness of empathy or attitude-based cultural competency training found that such training improved knowledge, attitude and skills among multidisciplinary health professionals and increased patient satisfaction (Beach et al., 2005).

It has been argued that the culture-specific model is a viable option for training mental health service providers who specialise in working with a specific ethnic group (Whaley & Davis, 2007). However, the culture-specific model may actually undermine cultural competency, as it can lead to an emphasis on difference as a disadvantage, through a process of 'othering' (Brown, 2009). 'Othering' may reinforce beliefs that the therapist is unskilled in working with ethnic diversity and therefore the solution is to refer clients to colleagues from BME backgrounds or increase the ethnic matching provision within the service (Kai et al., 2007). This not only disempowers therapists, but reduces their ability for self-reflection and an awareness of the prejudices, stereotypes, values and beliefs that have shaped their own identities (Brown, 2009).

Comprehensive guidance from professional bodies regarding cultural competency is lacking. Generic professional practice guidelines recommend that ethnic and cultural values be attended to throughout the therapeutic process (British Psychological Society, 2008). The Division of Clinical Psychology presents guidelines that make brief reference to attending to the client's race and culture (Division of Clinical Psychology, 1995). The Health Professionals Council Standards of Proficiency emphasise the need for reflexive and responsive clinical psychologists who are able to recognise the need for and make successful adaptations to their own clinical practice in order to better meet the needs of ethnically diverse clients (Health Professions Council, 2009). However, more precise guidance is needed to support doctoral training courses in incorporating these generic recommendations into training to increase cultural competency among trainees.

Methods of training in cultural competency

There are a number of different methods of increasing cultural competency available to clinical psychology training courses, including cultural immersion experiences, placement experiences, training on the academic curriculum and supervision. Different approaches are taken worldwide. For instance, in North and South America and New Zealand, some medical and psychology students participate in elective cultural immersion experiences, working with clients from different ethnic backgrounds, often overseas or interstate (Platt, 2010). Research suggests that participating in cultural immersion experiences increases cultural awareness in relation to the specific client group (Wood & Atkins, 2006). In the UK, cultural immersion experiences during clinical training are relatively rare. One example is the University of Leicester clinical psychology course, which is developing reciprocal placement schemes in Cuba, India, Ethiopia and the US (University of Leicester, 2011).

Cultural competency training can also include experience on clinical placements alongside academic teaching. Experience is integral in the pursuit of cultural competency and there are a number of ways in which clinical psychology courses can offer trainees experience of working with members of ethnically diverse communities (Yutrzenka, 1995). During training, students are expected to work with a range of clients, in terms of ethnic, cultural and socioeconomic variability and placements may be offered that increase the student's proficiency in working with clients from ethnically diverse communities. Experience during training is important, as research shows that qualified psychologists rate them-

selves as more culturally competent when they are exposed to greater levels of client diversity during training (Allison, Echemendia, Crawford, & Robinson, 1996). There is an increasing body of evidence that providing formal training in working with ethnic diversity alongside placement experience increases the formulation skills of psychotherapy trainees (Lee & Tracey, 2008). This emphasises the potential for formal cultural competency training to complement clinical experience.

UK clinical psychology training programmes vary in their approaches to ethnic diversity. The University of Surrey's clinical psychology training course aims to explore issues of diversity and difference throughout training (University of Surrey, 2011). The concept of ethnic diversity is fully integrated within the academic curriculum of several clinical psychology courses (e.g. Lancaster University, 2011; University College London, 2011; University of East London, 2011; University of Surrey, 2011).

Clinical supervision may offer another method of learning how to work with ethnic diversity, although the limited literature in this area is largely theoretical and presented using case vignettes (e.g. Yabusaki, 2010). This method relies on supervisors to create a safe learning environment in which the trainee can explore their own ethnic background, their assumptions, beliefs and prej-

udices and the complex interactions that may present when working with ethnically dissimilar clients (Yabusaki, 2010). Presently, there is an absence of literature relating to the impact of clinical supervision on cultural competency development among trainees.

Conclusion

Being culturally competent in working with ethnic diversity depends on many factors, including the comprehensiveness of doctoral training. Cultural competency models suggest techniques for therapists to work with ethnic diversity which should lead to improved therapy outcomes (Brach & Fraser, 2000) and reduced ethnic disparities in the effectiveness of mental health services for BME clients (Sue, 2003). Further research is therefore needed to determine the relative effectiveness of the methods described and the models that underpin them.

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How accessible and acceptable is clinical psychology to black and minority ethnic clients?

Charlotte Morris

This article discusses limitations associated with psychological interventions available in the NHS when working with individuals from BME groups. Also discussed is how clinical psychology trainees can be prepared for working with clients who have backgrounds different to their own.

THE UK is home to people from many different cultural backgrounds. In England alone, black and minority ethnic (BME) groups represent approximately one eighth of the population (Rethink, 2007). Despite the diverse nature of the population, interventions available within clinical psychology departments in the UK tend to be imbued with western values and as a consequence may be inaccessible or unacceptable to some clients from BME communities. Clinical psychology training seeks to prepare trainees to deliver evidence based interventions as qualified clinicians predominately within the NHS (British Psychological Society, 2010). However, if the interventions on offer are unappealing to a significant proportion of the population, due to cultural reasons many clients may be being excluded from psychological services.

It is therefore vital that clinical psychology training programmes educate trainees about the cultural biases inherent within existing psychological approaches. Furthermore, trainees need to be equipped with skills which enable them to sensitively explore cultural issues with clients, formulate how these may influence engagement and the therapeutic process, and then adapt their approaches accordingly. This article will highlight why some psychological interventions may be unacceptable to certain BME clients and outline how training programmes may prepare trainees for working with individuals from diverse ethnic backgrounds.

Due to a range socioeconomic factors individuals from BME groups are reportedly at greater risk of experiencing mental health difficulties compared to the white British population (Lloyd, 1998). In addition, individuals from BME communities are more likely to receive treatment whilst detained under the Mental Health Act, yet are less likely to voluntarily access mental health services (Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003). A number of reasons for poor uptake of services have been cited including language differences (Walls & Sashidharan, 2003) and unfamiliar routes to gaining help and support (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). However, the accessibility of services for BME groups is also likely to be linked to cultural differences in understanding distress.

In some cases, beliefs about distress held within BME communities are potentially incompatible with western psychological models. For example, some Muslim groups advocate spiritual explanations about the causes of distress such as attributing suffering to punishment from God (Weatherhead & Daiches, 2010). Spiritual explanations contrast with psychological approaches which tend to be based on positivistic philosophical assumptions and western concepts of mental health (Tribe, 2007). Indeed, evidence based interventions developed in line with scientific research have potential to be nonsensical for clients who understand suffering as having a spiritual cause.

Furthermore, psychological models such as Cognitive Behavioural Therapy (CBT), which are given significant weight during clinical psychology doctoral training, are based on western values including the 'individualistic' perceptions of the self. In the UK, as in other countries in the western hemisphere, individualistic traits which are compatible with capitalism including autonomy, strength and triumph over others are highly valued (May, 1977). However, in other parts of the world including Asia, Africa, Central and South America, collectivist, rather than individualistic cultures tend to dominate (Brislin, 2000). Collectivism emphasises relationships and the self is viewed as part of a larger system such as the family unit. However, psychological models developed in the west, which are based upon individualistic ideals, may in some cases be a poor match for BME clients who identify with collectivist values.

For example, in CBT, psychological difficulties are located within the individual in the form of 'negative automatic thoughts' or 'core beliefs'. Clients are viewed as agents of change who can learn to help themselves through utilising techniques which aim to highlight and correct cognitive biases. For some clients, attributing distress to individual deficits rather than locating difficulties within the family or the community could be unhelpful. More specifically, CBT may not give sufficient consideration to the broader contextual factors which are common amongst minority groups and may maintain distress and affect well-being (e.g. poverty, racism or isolation). Moreover, CBT encourages clients to identify and work towards specific individual goals. This is potentially an empowering experience for clients. However, Scheppers et al. (2006) suggest that an emphasis on individual goals and achievements can turn BME clients away from services because it requires the prioritisation of the individual's needs over those of the family or community. Indeed, in collectivist cultures independence may be seen as an undesirable trait and therefore CBT could be regarded as inappropriate approach when working with BME clients with collectivist values.

A further mismatch associated with collectivism and many psychological interventions is that therapy tends to be delivered on an individual basis. Although training courses seek to equip trainees with skills in working with families and systems, these are often developed in relation to child and family work. Within adult contexts training may emphasise the development of skills pertinent to the therapist-client dyad. Certainly, this is in keeping with traditional therapeutic approaches which are delivered on an individual basis and stress the importance of developing a strong therapeutic alliance within which the specifics of the identified model are delivered.

Although Cognitive Analytic Therapy (CAT) is a relational approach it is predominantly offered on an individual basis and the therapeutic relationship is regarded as the vehicle for change (Ryle & Kerr, 2002). However, the emphasis on the therapeutic dyad is largely based on a westernised understanding about relationships – yet in some BME communities relationships have different representations. For example, in some Asian cultures relationships are organised within a prominent hierarchical framework and 'elders' or those in positions of authority are seen as powerful, worthy of great respect, and expected to provide protection and guidance (Yi, 1995).

Clinical psychologists' professional position can elevate them to the role of an elder and as a demonstration of respect clients may behave in a submissive manner which has the potential to significantly impact on the therapeutic alliance and therapy (Yi, 1995). Within CAT the client and therapist are described as working through enactments of past relational difficulties which manifest within the therapeutic relationship (Ryle & Kerr, 2002). Repairing 'ruptures' is a key part of the therapeutic process, yet clients influenced by hierarchical templates for relationships are perhaps less likely to engage in challenging enactments with a therapist who they perceive as an elder.

Taking these issues into account, models which locate psychological difficulties within the system and work with the family

rather than the individual may be more acceptable to individuals from BME groups with collectivist values. In order for trainees to feel equipped to work in this way once qualified, it is important for pre-qualification programmes to provide training which incorporates the use of systemic approaches when working with adults with mental health difficulties.

Furthermore, programmes which equip trainees with skills in therapeutic approaches that are less bound together with western concepts of distress are more likely to produce qualified clinicians who are able to work effectively with individuals from non-western cultural backgrounds. 'Third wave' approaches such as Mindfulness and Acceptance and Commitment Therapy draw upon the spiritual influences of the east and incorporate Buddhist concepts such as radical acceptance. These approaches are becoming increasingly available within NHS contexts and may be more fitting with non-western beliefs about well-being and recovery. Nonetheless, psychological interventions and mental health services continue to be underpinned by westernised ideas about what represents psychological health and happiness. For example, in western cultures happiness tends to be associated with personal achievement whereas in East Asian culture happiness is often linked to social harmony (Uchida & Kitayana, 2009). Therefore, in preparing trainees to work with clients from non-western backgrounds, teaching which facilitates the deconstruction of western notions of well-being may be of benefit.

For BME clients, a further barrier to accessing psychological services relates to cultural perceptions of mental health. Current psychological interventions are grounded in the basic premise that talking about distress can be therapeutic, yet this view may not be shared by all cultures (Coll, 2002). Indeed, some Asian cultures view the discussion of inner experience as undesirable (Cushman, 1991) or culturally unacceptable (Rethink, 2007) and talking about emotions may even be regarded as harmful to mental health (Kleinman & Good, 1985).

Therefore, it is likely that considerable adaptation will be required if clinical psychology services are to develop wide appeal and improve inclusivity. One potential adaptation is the use of reflecting teams which include spiritual or community leaders and support clients through a problem solving approach (Jones, Moss, & Holtom, 1997). Indeed, greater integration and collaboration with faith-related communities may help to reduce the shame and stigma often associated with mental health difficulties. To this end, previous research has suggested that psychological services may improve accessibility through providing services at Mosques and community centres (Weatherhead & Daiches, 2010) and by adapting approaches so they are more compatible with religion (Adudabbeh & Hays, 2006).

Implementing such changes in a culturally sensitive way will require the input of clinical psychologists who have an understanding of the culture and values of BME groups. The majority of those entering clinical psychology training currently (and historically) are white, middle class females (see Turpin & Coleman, 2010) and therefore, diversification of the workforce is likely to be an important part of this process. However, this work should not be seen as the sole responsibility of BME clinicians. Indeed, improving access to psychological services is likely to work best if regarded as a joint venture in which all trainees are equipped with the skills required to effectively work with clients who have cultural backgrounds different from their own.

Although knowledge of clients' cultural norms and values can be useful and enable clinicians to place the client's difficulties in context, teaching about specific cultural values and traditions has the potential to create unhelpful and inaccurate stereotypes. Trainees are therefore more likely to benefit from the development of skills which enable them to open up conversations with clients and assess cultural values and beliefs. Yi (1995) suggests that during such conversations therapists should ask clients about their preferred language, social networks, family relationships and

their adherence to their cultural background. Such discussions will facilitate psychological formulations which weave in cultural aspects and enable clinicians to consider how culture may, or may not, influence engagement and thus serve as guide for culturally sensitive intervention.

Given the 'curious' stance adopted by clinical psychologists in their interactions with clients, we should be well positioned to work with individuals from cultures different from our own. However, it is unhelpful to assume that clinical training by its very nature equips us for this work. Indeed, although training does cultivate the development of skills in assessment and in producing individualised formulations, this is unlikely to routinely prepare trainees for working with individuals from different cultures. Indeed, given that clinical psychology represents a predominantly white western workforce delivering western psychological models, considerable effort is needed if psychological services are to become more inclusive. If trainees are to develop into clinicians who are capable of

improving accessibility and acceptability of clinical psychology, training should, as a starting point, emphasise the limitations inherent in current practices.

Additionally, training will need to facilitate the development of skills in incorporating cultural issues into assessment and formulation processes as well as providing guidance on the development and delivery of alternative interventions to those commonly on offer in the NHS. This work is likely to be challenging and potentially controversial, yet it has the potential to be mutually beneficial for clients, trainees and future services as well as the clinical psychology profession.

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Cultural competence: Social class – the forgotten component

Nicola Spence

Social class is often one of the least emphasised aspects of clinical psychologists' multicultural competence. This article highlights the impact of social class on our lives and the lives of our clients and considers the resultant clinical implications.

MULTICULTURALISM encompasses a broad range of factors, including social class, gender, age, language, ethnicity and sexual orientation (American Psychological Association, 2002). Within the field of psychology, the need for changes in attitudes and approaches has begun to be addressed, albeit slowly, for many multicultural variables, such as ethnicity, gender and sexual orientation (Arthur & Collins, 2005). However, these issues remain relatively unexamined in relation to social class (Smith, 2005). Indeed, it appears that social class is often a forgotten component when considering a clinician's cultural competence. This is despite it being recognised that a person's cultural identity and values cannot be fully understood without considering their social class (Ostrove & Cole, 2003). Thus, the available literature suggests that more needs to be known about how social class impacts upon people's multicultural identity and the implications of this for clinicians' cultural competence.

When conceptualising cultural competence, it is acknowledged that there is considerable overlap between the various factors of multiculturalism. Considering any one factor in isolation is artificial and does not reflect the lived experiences of individuals (Smith, 2005). Therefore, it is recognised that, in practice, the complexity of the *interactions* between an individual's social class, race, ethnicity, gender, sexual orientation et cetera must be considered. However, for the purposes of focusing this article, social class will be discussed as a relatively distinct entity.

Within the literature, there have been various ways to conceptualise social class proposed. Terms used include: low income, lower class and low socioeconomic status (SES). The term social class is used in this article in an attempt to capture the issues of power rather than characterise the experience of someone labelled as being of a particular social class.

Impact of social class

Research has shown that social class impacts upon every aspect of a person's life (Liu et al., 2004). Although not an exhaustive list, this includes educational opportunities, health (including mental health), housing, the crime rates in the neighbourhood, the food that they can afford, and what industries are built near their homes. In addition to these practical implications, there is evidence suggesting that social class also has psychological and emotional implications. For example, it has been shown that it is difficult for people to develop and maintain a positive lower social class identity (Pope & Arthur, 2009). Indeed, people classified as being of lower social class have been found to consider themselves to be inferior to those classified as being of higher social class (McMullin & Cairney, 2004). In understanding why this may be the case the upward mobility bias within Western society has been implicated (Liu et al., 2007). Unlike many of the other aspects of multicultural identity, the boundaries of social class are much more permeable (Pope & Arthur, 2009). Furthermore, the dominant

culture within Western society assumes that individuals are constantly interested in upward social mobility, achievement and success. Indeed, we often gain a sense of self-worth through individual success and achievement. Endorsing this upward mobility bias could result in characterising those who do not or who are unsuccessful in achieving upward mobility as lazy, deviant or unmotivated (Liu et al., 2007). As evidence of this, Cozzarelli et al. (2001) found that the following words were more often attributed to people considered lower class than to people considered middle class: uneducated, unmotivated, lazy, unpleasant, angry, stupid, dirty, immoral, criminal, alcoholic, abusive and violent. Furthermore, media representations of people who are economically disadvantaged typically portray them as dysfunctional, ignorant, unruly, promiscuous and users of drugs (Bullock et al., 2001). In modern British culture, various derogatory labels such as 'chavs' (in England and Wales), 'neds' (in Scotland) and 'knackers' (in Ireland) are applied to those considered of lower social class. In the context of such derogatory classist labels it is hardly surprising that it is difficult for people considered to be of low social class to develop a positive self-image. Conversely, endorsement of an upward mobility bias may place individuals considered to be of higher social class under pressure to confirm to the ideals of this group. Such restrictions could likewise limit the freedom and choice of these individuals (see Liu et al., 2007 for an illustrative case study). Thus, it is clear from the literature that social class identity should be an important consideration for clinical psychologists to reflect upon when formulating clients' difficulties.

Distancing

It has been proposed that individuals considered to be of high social class distance themselves cognitively, institutionally and interpersonally from people considered as being of low social class (Lott, 2002). It is suggested that this is an unconscious process that may override an individual's better intentions. One possible explanation for this distancing has been proposed as being due to it being difficult to relate to people who are economically disadvantaged because one has no desire to be poor. Another explanation suggested is that an individual may adopt a blaming attitude in order to feel secure in, and entitled to, their relative wealth (Pope & Arthur, 2009). As psychologists, this concept of distancing has important implications for our clinical practice.

Clinical implications

Succeeding in academia necessitates some endorsement of middle-class value systems (Nelson et al., 2006). It has been suggested that, as professionals, we are likely to adopt a middle-class worldview, which in turn may contain unconscious assumptions about people considered by society to be of lower social class. Of course, this is not to say that all psychologists will identify themselves as being middle-class. However, as will be discussed later, our income does afford us the *choice* to lead middle-class lifestyles and access class privileges that are not available to some others should we choose to do so.

As part of our reflective practice and multicultural competence it is important to be able to not only locate ourselves within the larger societal system but also to locate this system, including potential unconscious classist attitudes, within us. Indeed, the potential for such unconscious classist assumptions could influence our therapeutic relationships, formulations and interventions (Liu et al., 2007). In support of the importance of this issue, Smith et al. (2011) found that therapists with higher levels of belief in a 'just world' saw clients who were economically disadvantaged and working-class clients as more unpleasant to work with and more dysfunctional. Therefore, the literature suggests that as practitioners it is important to develop self-awareness of our own value systems and that of the wider society, and to be aware of the potential impact of these on our clinical practice.

As highlighted above, the economic income afforded to psychologists allows us the option of living a middle-class lifestyle even if we do not identify ourselves as middle-class. This position allows us to exercise a number of class privileges, such as freedom of choice, relative stability in our lives, societal support, knowledge of socially acceptable behavioural repertoires and etiquette, access to high quality services, and upward mobility. Liu et al. (2007) composed a list of specific class privileges that includes: the ability to obtain loans/mortgages, expecting to retire with a sufficient income, being able to eat three meals per day with a variety of choice and nutrition, having a reasonable expectation that our children will be as or more prosperous that us, and being able to spend time and money on superficial concerns. Class privileges are often unconscious and invisible to the people who are graced with them and are often exercised unknowingly (Liu et al., 2007). Thus, developing our awareness of the exact class privileges we exercise could enable us to assess the impact of these experiences on how we conceptualise the lives of the people with whom we work.

Continuing professional development
The issues raised in this article have important implications for individual practitioners, clinical psychology training courses, supervisors and the profession as a whole. As individuals, an important part of advancing our multicultural competence as psychologists is to develop our awareness of our personal values and attitudes with regard to social class. This includes being mindful of any unconscious internalised classism that may impact upon us as a result of the dominant societal discourses in relation to the issues of social class. Training courses also have a responsibility to equip practitioners with the skills necessary to incorporate the complexity of the issues related to social class into their clinical practice. The American Psychological Association has produced resources for the inclusion of social class in course curricula, which may be beneficial to both training institutions and individual practitioners (American Psychological Association, 2008). Providing further support in practitioners' continuing professional development, Smith (2009) suggests five inter-related areas relating to social class for supervisory action.

Summary and conclusions
Social class is a multicultural variable that impacts greatly, consciously or unconsciously, upon all of our lives, and this has implications for psychologists' clinical practice. It is an inaccurate oversimplification to attribute clients' difficulties to individual factors without considering their social circumstances and class identity. Indeed, economic and social realities are rooted in many clients' difficulties and therefore a systemic understanding is vital in gaining a thorough appreciation of potential causes of, and barriers to overcoming, clients' difficulties. This has a number of implications for our clinical practice. In addition, as psychologists, it is an important part of our multicultural competence to consider how our own personal social class identities impact upon our clinical practice, to develop our ability to incorporate social class into our formulations when working with clients across the entire spectrum of social class,, and to consider whether different modes of intervention are indicated by different social groups. Furthermore, due to the relative lack of the research into social class and clinical psychology, future research is warranted to explore these issues further, including how accessible and acceptable current service provision is to people across the entire social class continuum.

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Is culturally sensitive research achievable?

Aneela Pilkington & Rachel Msetfi

Culturally sensitive practice, both in the clinical and research context, is becoming more important as the world becomes increasingly multicultural. The aim of this article is to look at culturally sensitive research in the context of a study completed as part of a clinical psychology doctoral thesis. The article examines whether we can be culturally sensitive in research, as well as addressing barriers and possible solutions.

THE WORLD OF RESEARCH is changing to accommodate the many studies that focus on different cultures, and not just the dominant cultures in the western world. In the last decade in particular, we have seen an increasing number of research studies focusing on diverse cultures, particularly in the field of mental health and psychological wellbeing. Understandably, this calls for culturally sensitive approaches and has led to increased discussions around conducting research that examines different cultural groups from the perspective of one culture (the dominant culture). The aim of this paper is to discuss issues around addressing cultural sensitivity arising from our personal experiences of conducting research with a population of British Muslims of South Asian origin (see Pilkington, Msetfi & Watson, 2011). The research was conducted as part of a clinical psychology doctoral thesis.

In order to contextualise these discussions, we will summarise the background and aims of the Pilkington et al. (2011) study. We were interested in finding out how feelings of shame affected the likelihood of people seeking out psychological help. Although personal shame and humiliation in relation to the perceived stigma of mental health problems has been a frequent topic of study (e.g. Cinnirella & Loewenthal, 1999), shame can be a distinct construct with particular meaning for some cultural and religious groups. For example, in individualistic cultures, feelings of shame relate to reflections on the self (Mesquita, 2001). However, within South Asian cultures reflected shame is related to 'izzat'. This is a term that is used to describe a complex set of rules that must be adhered to in order to pro-

tect the family honour and keep position within the community. Previous qualitative research had identified izzat as playing a role in help seeking and using mental health services (e.g. Anand & Cochrane, 2005), and one aim of our study was to examine the predictive value of izzat using quantitative methods.

The theoretical framework used for this research was the Theory of Planned Behaviour (TPB: Ajzen, 1985), which has been reported to generalise across cultures (e.g. Phoenix & Winnie, 2009). TPB can be applied to intentions to carry out any kind of behaviour but is most frequently used in the field of health behaviours. Utilising this framework, we also examined more established predictors of intention to access psychological services. These included beliefs about the cause of mental health difficulties (biological/social-environmental and religious), levels of acculturation and demographic variables such as age and education.

To briefly summarise the results, levels of education and acculturation were positively related to intention to seek help, whereas biological beliefs about the causes of mental health disorders and izzat were negatively related. So, stronger beliefs in biological causes and higher levels of izzat predicted less intention to seek help. However, when data from individuals that had migrated to Britain during their lifetimes was examined separately to individuals that were born in the country, the picture was somewhat different. Levels of education remained a key predictor of intention for both groups. However, for individuals that were born in Britain, only acculturation predicted intention. For the migrant group, increased length of time in Britain predicted

stronger intention and higher levels of izzat predicted lesser intention. Although there are always power issues in relation to splitting samples in this manner, it seemed equally important not to ignore differences between migrant individuals and those born in Britain. It was this finding in particular that prompted us to consider issues around conducting culturally sensitive research.

At a fundamental level, cultural sensitivity is being aware and accepting of other cultures. Within our research, we deemed culturally sensitive practice to include an awareness that differences may exist between the culture of the dominant group and that of the target population. This included differences at a number of levels including conceptualisations of psychological difficulties, beliefs, values and behaviours. We also felt it was important to immerse ourselves in the traditions of the cultural group that we were examining. It is important to note that one of the researchers was from a South Asian background. Finally, our research aims and questions were defined by previous research and not by preconceptions about British Muslims of South Asian origin.

As in any good research, it is important to reflect on the research process once the study has been completed. We did feel that we had met the criteria we set for ourselves to ensure that we had been culturally sensitive in our approach to the study (for full details see Pilkington et al. 2011). However, when reflecting on the research process, a number of further issues arose.

The design of our study had a fundamental flaw in relation to cultural sensitivity as we were unable to provide translated versions of the measures. It would seem to be quite obvious that, in order to ensure culturally sensitivity, we should provide participants for whom this was necessary with translated versions of the measures. However, the majority of the questionnaires used in this research had not previously been translated into and validated in the relevant languages. The required translation, back translation, and validation process would also have been beyond the scope of this project carried out, as it was within the framework of a clinical psychology

doctoral thesis. However, we then started questioning whether, even if we had been able to provide translated versions of the measures, we would then have met the criteria for conducting culturally sensitive research.

In particular, it is important to think about the process of translating measures that are designed from the perspective of a particular culture and then utilising them within different cultures. Although it is important to ensure that measures are linguistically accessible, this does not mean that a direct translation of a measure makes it linguistically sensitive to different cultures (Edwards, 1994). Therefore, simply translating the words from the English language to different languages would be unlikely to account for grammatical differences, variations in semantics and conceptual equivalences.

As with any debate in this field, raising one issue inevitably throws up a whole host of other issues. Specifically, even if the measures had been available in different languages, the concepts in these measures stem from a Western theoretical framework. We wanted to examine people's understanding of the causes of mental health difficulties and whether they were likely to seek help for such mental health problems. Our measures of these variables were of course predicated on the assumption of a shared understanding between researchers and participants of what constitutes a mental health problem. However, there may be considerable differences between cultural and religious groups as to what a mental health problem is. Therefore, in this type of research it is also important to consider cultural conceptualisations of mental health, and whether the cultural group being researched has a similar understanding of mental health and psychological distress to that of the dominant culture.

For example, there are inherent differences between South Asian populations and Westernised societies in terms of key aspects of the self and context relevant to mental health. There are several approaches to studying cultural differences but the dominant paradigm is that of individualism and collectivism (Oyserman, Koon & Kemmelmeier, 2002). South Asians tend to be collectivist and allocentric, such that value is

placed on collective needs and collective self-definitions (Triandis, 1996). Emotional dependency is also fostered within the family system (Patel & Gaw 1996). Conversely, Western cultures are seen as individualistic, where the rights of the individual and personal goals are emphasised and independence and autonomy are promoted (Phinney, Madden & Ong, 2000). Clearly, it is individualistic notions of self that pervade contemporary theories of mental health.

The collectivist-individualist distinction is not the only framework that has been applied in this domain. Another relevant example is the suggestion of a continuum between 'sociocentric' and 'egocentric' perspectives on thoughts, behaviours and emotions (Gaines, 1982). 'Sociocentric' describes individuals who view behaviours, cognitions and emotions as functions of relationships, whereas 'egocentric' refers to individuals who perceive themselves as autonomous, with behaviours, cognitions and emotions arising from the individual. South Asian identity is thought of as sociocentric, which again is inconsistent with egocentric Western theoretical views of mental health (Triandis, 1996). The implication is, therefore, that Western theoretical perspectives on mental heath may be limited in terms of their explanatory power for members of cultural groups with collectivistic orientation.

The idea that fundamental differences exist in the conceptualisation of mental health between South Asian and Western populations was demonstrated in a study examining the construct of depression in Pakistani groups (Malik, 2000). From interviewing participants who were either living in Pakistan or were first generation migrants to Britain, some differences were observed between the perceptions of participants in this sample and how depression is perceived within a Westernised framework. In particular, it was found that the perceived cause of distress tended to be related to external factors, such as situations and relationships, rather than internalised. Furthermore, the symptoms of distress were expressed in relation to social roles and other people.

Reflecting on the findings of this study made us wonder whether there was not a more fundamental difficulty with the Pilkington et al. (2011) study. Did the use of the measures adopted assume that all of our participants subscribed to a Westernised framework of mental health? If this was the case, then the ideas in the questionnaires may have meant something different to the respondents to that assumed by the researchers. Indeed, most of the measures had not been validated with South Asian populations. This means that we need to exercise caution when generalising from the results, as they may only be relevant to certain groups of British Muslims. Given that the sample recruited into this study were mainly from Britain (and if they had migrated, they had been living in the country for some time), it is possible that they were more familiar with Western frameworks for understanding and treating mental health and therefore the findings of this study may only be generalisable to this group of Muslims.

One solution, which could avoid such problems, is to use instruments that have been designed specifically for the cultural group being studied. However, this is not as straightforward as might be assumed. For example, the Armistrar Depression Inventory is a measure of depression that has been developed and validated in Pakistan. Bhui, Bhugra and Goldberg (2000) tested this measure with Pakistani respondents in the UK and it was found not to be an accurate measure of depression for the UK group. This suggests that the process of migration and subsequent acculturation into a new country leads to some cultural shifts. Therefore, it may be that we cannot view cultures simplistically as either collectivist or individualistic, but rather that there may be a continuum between these cultural orientations, which will be affected by individual experiences, values, behaviours, beliefs and identity.

Zebain, Alamuddin, Maalouf and Chatila (2007) also offer some interesting ideas that could be used to address culturally sensitive research practises retrospectively and

include looking at conceptual and method-ological issues as well as employing valid methodological procedures. Finally, it may be a good idea to utilise the resources that we already have and look at literature into service-user led research, thus linking in with different cultural/religious groups to use their expertise in helping with the path towards culturally sensitive research.

Overall, the area is complex and there may be no simple answers that ensure research is culturally sensitive. We feel that there is most probably a spectrum of cultur-ally sensitive practice. This will, of course be affected by practical constraints, as was the case in Pilkington et al. In particular, the research presented was part of a clinical psy-chology doctoral thesis and this meant that issues of restricted time and finances affected some of the practices around cultural sensi-tivity. However, we do feel that there are fun-damental components that can be adhered to despite such practical limitations. It may be easier to view these as different levels of culturally sensitive practice, ranging from the fundamental level to the gold standard. So, to answer our initial question, we do think that it is possible, at least at some level, to carry out culturally sensitive research.

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'Health on the road to your heart': Cross-language and cross-cultural challenges in consulting on mental health with a Cambodian orphanage

Katie Splevins & Anna Daiches

The following article is reflection on the cross-cultural and linguistic aspects of working as a consultant to the founder of an orphanage in Cambodia as part of a final year trainee placement.

AS PART OF a specialist third year clinical psychology placement I was invited to undertake a short piece of consultancy work in Cambodia. The work was commissioned by Penny (all names and identifiers have been changed to protect anonymity), an ex-colleague and founder of an orphanage in Battambang province, north-western Cambodia. Penny cared for 18 orphans, aged three months to 18 years, all of whom had been subjected to extreme poverty and neglect. The children had all experienced multiple and severe traumas (e.g. physical, emotional and sexual abuse, being trafficked, HIV/AIDS) and many of the children displayed behaviours such as aggression, withdrawal, bedwetting and hoarding. Although Penny managed a staff team of six Khmer employees (a director, a house-mother, a house-father, a counsellor, a cook and a security guard) neither she nor her staff had undergone any mental health training. Furthermore, Penny felt her staff team were not working with her to resolve the problem behaviours. Driven by a desire to both understand the cause of such behaviours in the children she cared for, and by her experience of alienation from the care team, Penny contacted me, as a psychologist in training, for advice on how to address the children's psychological needs.

Penny initially approached me asking whether I could 'do therapy' with the children as she felt certain their childhood traumas were the root cause of the perceived problem behaviours. Not having assessed the children myself, nor being an expert on psychological health and healing in the Cambodian culture, I felt this was inappropriate. I did, however, agree to spend a brief consultation period with Penny during which time I would observe Penny, the children and her team and offer some reflections on how to take things forward both in terms of her relationship with the staff and the children's' mental health needs. The ultimate aim was to work with Penny to develop more insight into the system in which she worked in order to help her and the team to find their own solutions to some of the difficulties they faced. With a clear supervision structure in place, I agreed to spend eight days in Cambodia.

Previous experience of working overseas had taught me that no amount of reading or research prior to departure could adequately prepare me for the cultural and linguistic challenges ahead. Cultural psychology posits that the self and culture are mutually constituted and inseparable (Markus & Kitayama, 1991), and I was aware that I could not entirely step outside of my own worldview nor completely understand a culture other than my own as a white, British, middle class woman. However, I felt it was important to learn as much as possible about the socio-political, historical and cultural context in which I was to be working in order to enhance my ability to be helpful to Penny. I felt my usefulness in

Cambodia would be improved with adequate preparation which took on four main strands. First, to become familiar with the Cambodian culture in general; second, to gain insight into Cambodian models of health and healing; third to ensure I had adequate means of communicating; and finally, to remain aware of my own cultural background and the influence this might have in my decision making and the way in which I interpreted things.

To increase my understanding in these areas, a two-month period of preparation prior to departure included much reading, watching of relevant TV documentaries and phone discussion with mental health workers in Cambodia. Once in Cambodia I had conversations with local Khmer lay people, mental health workers and healers, and representatives of non-governmental organisations (NGOs) caring for orphans. Most importantly, I also had opportunities for observation and informal discussion with the staff and children at the orphanage. I kept a detailed diary which helped me reflect on my own journey and to recognise some of my own implicit assumptions.

Initial discussions with Penny highlighted her belief that a major problem preventing the resolution of the children's behavioural difficulties was that the staff team's work ethic was poor; that they were 'lazy' and did not contribute to discussions about the children. Furthermore, Penny felt that while the staff often agreed to implement any new idea that she might suggest, they would just as often fail to put it into practice, or would do so in what Penny felt was a half-hearted manner. As a result, Penny had become increasingly reluctant to delegate to her 'untrustworthy' staff team.

My own research, observations and discussions provided me with an alternative explanation for this dynamic. A general reverence to the West and to Westerners (the result of several centuries of Western imperialism) combined with the strong hierarchical social structure that characterised Khmer society might have led the care staff to feel it would be disrespectful and inappropriate to refuse Penny's requests. For example, on arrival in Cambodia, I found that white people would be offered a seat on busy buses in preference to Khmer people, regardless of other considerations such as age or disability. During professional staff meetings at other orphanages in Cambodia the Western viewpoint was usually given priority, with local staff often praising Western interventions over their own local healing practices. Furthermore, respect for a hierarchical social structure meant the opinions of elders or those perceived to be in a position of knowing, such as teachers or managers, were not challenged. In addition, the local people I spoke to described the value they placed on being able to fit in with the perceived thoughts, feelings and goals of others in order to promote interpersonal harmony. Markus and Kitayama (1991) termed this way of thinking as being representative of an interdependent culture where the sense of self is inseparable from the social context, and social harmony is valued above asserting the self as a distinct and autonomous being. Together, these observations and this information led me to hypothesise that 'passive' staff behaviour was a sign of respect for Penny and an attempt to maintain a social equilibrium in the workplace.

Further complicating the picture was the continuing aftermath of one of the worst genocides of the 20th century. From 1975–1979 the Khmer Rouge under Pol Pot murdered anyone they thought to be an intellectual in an attempt to establish a communist state led by rural collectives. It has been estimated that up to 1.7 million people died during this time and families were forced to betray other family members in order to save their own lives, creating an atmosphere of mistrust and paranoia (Kiernan, 1998). Among the many social, economic and psychological consequences was a deep lack of trust in others. This was talked about both by Khmer healers and care staff members themselves. This lack of trust in others may also have made it hard for the staff team to share their difficulties, opinions and fears with Penny and/or each other, thus hindering a team approach to work, or requests for help when needed.

The same avenues of research also provided me with another way of understanding how Penny and the staff viewpoints differed when caring for the children. 'Health pluralism' refers to the varied way in which cultures may understand and deal with distress (Tribe, 2007) and with this in mind I spent time researching how local healers dealt with psychological difficulties. Fortune tellers were still widely used and local practices like hair-pulling were often employed to mute headaches, while cupping or bleeding were sometimes used to cleanse people from various physical and psychological ailments. However, the majority of Cambodians were still living well below the official poverty line and this meant that for many local people, addressing psychological needs was not a priority. Food, water, shelter and a basic income were all that most people could think about. I was, however, informed that counsellors and healers were beginning to give up traditional models for the interventions of the West brought over alongside NGOs and charities aiming to support Cambodian people and the idea of one-to-one therapy was commonly accepted.

As previously mentioned, Cambodians value a strict social hierarchy which was reflected in the language used to address people of various social standings (for example, Khmer people have greeting words that differentiate between 'woman older than yourself but younger than your mother' and so on). In the orphanage, behaviour on the part of the children that did not respect this social hierarchy (such as disobedience) was considered significantly problematic by the staff team, but a relatively minor problem by Penny who felt the children were just 'expressing their individuality'. For example, touching the head of a person older than yourself is considered highly disrespectful in the Cambodian culture. However, the children often touched the hair and head of the mostly Western volunteers working with them in a way which was considered acceptable by Penny but which created confusion for both children and staff about what would be tolerated. In addition, psychological health, as perceived by the

staff team incorporated obedience and compliance with staff views and opinions. In contrast, Penny interpreted these forms of conduct as signs of withdrawal and preferred to encourage the children to 'find themselves' and be outspoken about their needs and beliefs.

Based on the advice I had been given, I set up informal meetings with the staff, to talk a little about my stage of training and desire to understand more about how mental health needs are understood and responded to in Cambodia. These were informal groups discussions, supported by a trusted interpreter who worked as a cultural broker (Raval, 2003), providing a cultural context to interpretations for both myself and the staff team. In normalising how difficult it is when working with looked after children, I was surprised at how quickly the staff team opened up, one member confessing that he wanted to quit. The staff appeared to have no way of making sense of the children's behaviours and expressed a sense of shame at their own perceived inability to resolve difficulties. In response, I introduced the concepts of attachment theory as a framework within which we could began to make sense of some of the behaviours exhibited by the children which concerned the team. Such behaviours included 'attention-seeking', hoarding and not attending at school. The concepts of safety within an attachment framework, also provided an opportunity to normalise a human need to feel safe. Disclosing my own experiences of feeling unsafe in a team environment appeared to allow the team to begin to talk about their own difficulties and to share their distress and concern for each other. This openness allowed Penny to hear the staff's concerns for the children and to begin to empathise with the team and their own need for support.

As the week progressed we were also able to explore what a 'mentally healthy' child looked like. Our progress in debating this issue was slowed by the need to interpret - not just the word - but the conceptualisations of each topic of discussion. While the English language has multiple emotion words, the

Khmer language largely uses two words to represent a range of emotional states. Concepts such as 'attachment' or 'attunement' had no immediate parallel in Khmer and many understandings and concepts were acted out using a child's doll. Analogies which were meaningful to the staff team (farming analogies) were often a useful way to convey ideas and in turn I had to try and understand the notion that at times a child might be affected by 'bad spirits' and that this might be better exorcised than treated with therapy. While there was no easy resolution to what was best for the children, space was given for the beginnings of a discussion whereby members of the team could feel heard and understood. Furthermore, the team identified an important first step which was to improve communication between themselves and find a way to be consistent in the way they approached the children. Thus, while the discussion had no firm conclusions the process appeared to be healing and to renew their motivation for the work, with one staff member sharing that he felt his enthusiasm for the work had been 're-ignited'. The literal translation of 'mental health' in Khmer is 'health on the road to your heart'. This concept expresses the idea that emotional pain would not heal if it was kept pent up in the heart but that it needed to be acknowledged – a concept everyone seemed to be able to agree on and use as a pivotal point in the ensuing discussions.

At the end of eight days the staff and Penny had a systemic formulation which seemed to have helped them make more sense of their difficulties. They were also able to use attachment theory as a framework for better understanding child behaviours and were beginning to engage in a discussion about what constituted mental health and how that might differ according to culture. However, there were also aspects of the work which I had not anticipated. First, my intention to explore and reflect on processes rather than provide answers was initially impeded by the use of the term 'consultancy' which had led the staff team to believe I would 'fix' problems. Additionally, use of this term gave me

unwanted status. I attempted to address this as much as possible by open discussion about my role and developing a collaborative working relationship where we worked towards a joint understanding of some of the team dynamics, including my temporary place in the team. In retrospect, it would have been preferable to have been introduced as a co-worker rather than consultant, although whether this would have fully eliminated expectations on me as a 'Western expert' is debatable. Second, I used concepts from attachment theory as a framework within which we began to makes sense of both difficulties within the team and behaviours exhibited by the children. Had I had more time, I would have preferred to spend longer exploring, and perhaps developing, another framework of understanding which was not steeped in a Western cultural worldview. While my intuition and the feedback I was given suggested these aspects of the work had not taken away from the overall value of my visit, my ability to accurately evaluate the impact of the intervention was impeded by a desire on the part of the staff team to compliment me. While post-intervention reports from Penny indicated that the team were more cohesive, had support systems in place and regular 'open' discussions' which allowed them to problem-solve together, I still find it difficult to know whether my work was useful or simply perpetuated the imposition of a Western worldview on others.

What this experience highlighted was that no matter how much we try to be open to cultural differences we can only really understand anything within our own cultural frame of reference. Being an outsider to the culture made it easier to recognise my own assumptions and biases and forced me to check my understandings. However, I still believe it is possible that I wrongly assumed I had understood certain Cambodian concepts. Taking on the role of trainer, albeit in the most collaborate way I knew how, could only have made it more difficult for the staff team to point out any misunderstandings on my part.

Being reflexive can be even more difficult in your own cultural setting where these discrepancies and assumptions are not so obvious. This work reminded me that since most psychologists working in the NHS are white and middle class like myself, it is easy to lose sight of the fact that we are often working with people from a wide variety of cultures and backgrounds that differ from our own and, unless we see a non-white skin colour or hear a different accent, we can forget this. However, it must also be acknowledged that a shared culture is not synonymous with a shared worldview, and there are important variations within cultures relating to issues of gender, social class, migration and religion, among others.

Currently, the UK has a diverse population and it is recognised that healthcare services are not universally appropriate or accessible and can promote the marginalisation of minority ethnic groups (Fernando, 2005). Without reflection and continuously questioning our conceptualisations and assumptions, people (including psychologists and other mental health workers) may inadvertently be involved in this kind of marginalisation of minority ethnic groups. Prior to my work in Cambodia I felt the marginalisation of others and promotion of a Western culture were easily avoidable, but the reality of working overseas highlighted to me the scale and complexity of such work. While I personally found the experience challenging and inspirational, I came away feeling not that I had learned more about working psychologically and ethically across cultures, but that even more questions had been raised both with regard to my work in Cambodia and to my work as a psychologist in general.

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Embarking upon clinical psychology training: Our relationship to change within a learning group context

Rosie Powling, Manveer Kaur, Kaanan Butor-Bhavsar, Michelle Miles, Catherine Atnas, Jemeela Hutchfield, Helena Kaliniecka & Naomi Spokes

This article explores our relationship to change as trainee clinical psychologists commencing training. We offer some reflections about the first year of clinical psychology training and highlight the benefits of reflective group tasks.

AT THE START of clinical psychology training our cohort was divided into personal and professional learning discussion (PPLD) groups, each consisting of eight group members. These groups offered a safe space to reflect on our experiences of training – for example, in terms of clinical work, ethical and service development issues.

This article explores our relationship to change as trainee clinical psychologists, including what change meant to us and how it impacted upon our clinical practice during the first year of training. Our aim is to offer some reflections about commencing clinical psychology training and highlight the value of group tasks in developing reflective practice.

Our reflections have arisen as a result of a problem-based learning (PBL) task on 'the relationship to change', with which we engaged within our PPLD groups, whilst preparing a presentation over a five-week induction period. We were given general prompts about how to proceed, but were encouraged to make our own interpretation of the task.

The group process
Development of ideas
Initially, our discussions focused on personal change, which was understandable in the context of us all having commenced the course and perhaps having made life changes in order to do so. As a result, some of us felt resistant to further change, a defence perhaps to pre-training hearsay that suggested we would transform during the course and lacked control over this process ('I hope that the core of who I am will remain the same').

Our discussions shifted into the exploration of change within a wider framework, including social, political and cultural contexts. In order to engage with a cross-section of the literature, each group member investigated a different domain of change and reported back to the group. These domains included different theories, for example the Transtheoretical (stages of change) Model (Prochaska & DiClemente, 1983), ideas involving group processes (Bion, 1961) and changes in group identity (Elstak & Van Riel, 2005). We also considered change within ourselves and our clients, as a result of working within different therapeutic orientations, such as cognitive behavioural (Bennett-Levy, 2003) and psychodynamic models (Howard, 2005).

We finally decided to focus our presentation on the process of how our PPLD group was changing over time, by working within a critical reflections framework (Rolfe et al., 2001). This involved reflecting upon what we did (descriptive level of reflection), why

we did it (incorporating theory and knowledge) and what this meant for our clinical practice (reflexive level of reflection). We illustrated these ideas through a collage, which was an idea inspired by Ernst and Martin (2006).

How the group evolved

Establishing ground rules, organising a set format and assigning a chair and scribe for sessions helped to contain our anxieties and implement structure. There were many advantages of tackling the PBL task as a group. These included the fascinating group process that ensued, the rapid bonding of our PPLD group and the large amount of research and knowledge that could be investigated and shared by the involvement of eight people.

It was interesting to observe the group dynamics over time. In the first couple of sessions there was a lot of talking over one another. In hindsight, the need to articulate our opinions was perhaps a combination of feeling vulnerable and anxious, particularly in the context of establishing ourselves within such a competitive course.

Following these initial sessions, group members were able to share personal reflections with each other. Some group members believed that they should relinquish the urge to control. Other quieter individuals were concerned that their contributions might be less valid or that they would need to change their communication style in order to cope with the more dominant voices ('I need to jump in quickly with points or I won't ever get to say anything!').

A few group members felt more contained when our facilitator was present, perhaps because they valued her wealth of experience and competency. Others felt more inhibited in the presence of a perceived 'authority figure' and considered it was easier to conflict or stray from the rules when she was not present. Our facilitator was absent in the fourth session, which was the closest our group came to 'storming' according to Tuckman's (1965) model.

This storming was indicated by the collapse of structure within the session and the temporary psychological withdrawal by two group members, who felt that the conversation was circular and chaotic. Frustrations were also experienced by the chair who felt inadequate because of her inability to manage these issues.

As the group arrived at a consensus regarding how to proceed with the task, and the facilitator returned, the dynamics changed as group members felt more contained and there was a growing sense of teamwork. This led to the group 'norming' and 'performing' (Tuckman, 1965), through channelling our energy into the task.

Difference and diversity

As a group we were all females in our twenties and thirties, from a mixture of middle and working class backgrounds. The majority of group members were white Caucasian; two were of Asian ethnicity. Diverse cultural and religious backgrounds were represented by group members who had first-hand or familial experiences of growing up in a range of developed and developing countries across Europe and Asia.

We acknowledged that these differences within the group influenced multiple aspects of our personal and professional development. One example when this was highlighted was during a discussion about an article regarding learning narratives in group supervision, which proposed that our previous experience of learning shapes how we communicate and approach collaborative group learning (Aggett, 2004).

We considered how our previous experiences and personal qualities impacted upon the group and its decision-making during the PBL task. This has helped us to appreciate group processes on placement and consider how our language and formulation styles negotiate more medical-oriented narratives within multidisciplinary teams (MDTs).

In terms of communicating as a group, we initially had a tendency to be over-polite with one another, which made rejecting ideas and progressing with the 'best' idea difficult at times, but also resulted in some richer, more meaningful

conversations, whereby we validated and developed one another's ideas.

We often struggled between establishing ourselves within the group context, striving to prove our competency and wanting to be liked. Similar difficulties can be experienced within therapeutic relationships we discovered, such as when we ask clients to engage in challenging tasks in therapy.

Over time we learned to revise initial judgements about each other, appreciate our different working backgrounds and use our strengths to the group's advantage. Hence we learnt not only to appreciate, but also utilise the group's differences and diversity. This appreciation and utilisation of individual differences is important within MDTs and therapeutic contexts.

Impact on clinical practice: Therapeutic change

During group discussions we observed that change can be empowering and disempowering. This idea is of considerable importance in clinical work. The overall goal of many forms of therapy, for example cognitive behavioural therapy (CBT), is to empower clients to make changes.

Additionally, our judgements about ourselves within the group were at times empowering us to change, but at other times acted as unhelpful, dysfunctional assumptions, which parallels our clients' experiences. Although CBT focuses on change within the client, the systemic effects of change can result in social and cultural change within relationships, families and communities.

Feelings that group members experienced during the task may parallel those of clients and carers, for example feeling unheard, unable to change, self-conscious and out of control. We found that our own emotional and motivation levels mirrored the group as a whole and over the year, we have noticed parallels in our therapeutic work.

For example, when clients feel motivated we believe we are better therapists. When clients appear de-motivated we can think that the therapy is 'stuck' and our self-confidence is reduced. We can feel frustrated and overwhelmed at the progression of therapy,

the responsibility we feel as therapists and the struggle to work collaboratively at times.

As novice therapists, our anxieties may hinder active eliciting, exploring and appropriately responding to clients' and carers' concerns. Discussions at the start of therapy have highlighted the importance of adequately preparing clients and investigating the potential impact of change in order to assess readiness for treatment, enhance motivation and instil hope.

Over the year we have noticed how we place great emphasis on change as an outcome that can be measured, but on reflection, might there be therapeutic benefits for clients despite the evidence from outcome measures, particularly symptom-based questionnaires? Does psychological assessment always allow time to capture personal growth? And what about change as a means to enhance positive wellbeing, as opposed to simply reducing psychological distress?

This shift towards positive psychology has gained more momentum in recent times (e.g. Seligman, 2002). As such, we need to continue to facilitate the progression of mental health culture from the traditional perspective of symptom reduction to facilitating change towards a client's personal meaning of recovery.

Finally, the experience of the PBL task helped several group members to develop their facilitation skills in therapeutic groups on placement. We recognised similarities in our levels of anxiety and fears of being seen as 'incompetent', but also noted our abilities to rise to the challenge and defy our own perceptions of ourselves.

Ethical issues

Honesty and reflection in supervision are vital in the constant strive to develop as reflective scientist-practitioners. As the roles of clinical psychologists develop within a shifting NHS (British Psychological Society, 2007), achieving change within MDTs is a challenge to which we believe clinical psychologists should rise when necessary.

For example, a derogatory comment was made about a client of one group member by another professional within

her placement team. She felt offended by this comment and thoroughly disagreed with him. However, she did not want to threaten her professional relationships and was aware that she was young and inexperienced in comparison to the professional, so light-heartedly challenged him. As we develop in our professional roles, we hope to be able to act in such situations with more confidence and endeavour to achieve more enduring changes in MDT attitudes. These changes in our clinical practice are grounded in the endeavour for change and are vital for our professional development.

As encouraged by our facilitator, our discussions became increasingly client-focused and integrative over the year, developing our confidence in our clinical judgement and in critical discussion of NHS services. For example, one group member raised a dilemma about wishing to honour an Indian Hindu client's request for his wife's presence in therapy sessions, which contradicted the one-to-one standard practice of the specific service. Having the confidence to adopt an integrative approach following the group discussion secured the client's engagement with therapy, as it valued his systemic and cultural beliefs (Sharma, 2000).

Final remarks

The PBL task gave us experiential learning of how multiple perspectives and peer support can enhance personal and professional development. The safe space that we created was vital for us to express our thoughts and concerns and it also enabled group consultation for members seeking assistance. This reflects the importance of a safe space within a therapeutic context and allowing adequate time to build a trusting therapeutic relationship, which is often considered the key component in aiding therapeutic change (e.g. Luborsky et al., 2002).

It would be interesting to consider how different the process may have been had the group consisted of different members. For example, if the group had not been all-female or if our personal qualities had impeded the development of collaboration. We believe it is important to note that our ability to work together, whilst also asserting our individual viewpoints, were crucial elements to us being accepted onto clinical training.

These skills will continue to be developed throughout our careers as we strive to strike a balance between collaborative inter-personal working and leadership, both of which are highlighted in the New Ways of Working for Applied Psychologists (British Psychological Society, 2007).

We hope this article develops readers' awareness of group dynamics that can arise from course demands, highlights the initial process of becoming reflective scientist-practitioners and offers future trainee clinical psychologists some insight into the experience of the first year of training.

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Book reviews

Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America
by Robert Whitaker
(Crown Publishing Group, 2010)

Demedicalising Misery: Psychiatry Psychology and the Human Condition **by Mark Rapley Joanna Moncrieff and Jaqui Dillon**
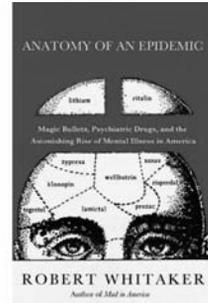**(Palgrave Macmillan, 2011)**

Reviewer Richard Pemberton, University of Brighton

These are two timely and important books. They both cogently challenge 'the simplistic and pessimistic biological models' that continue to hold sway in much of current mental health care. Rudi Dallos says in the introduction to *Demedicalising Misery* we need not only reflective practice but also a complacency monitor. Both of these books troubled me about the service norms, and reductionist asocial psychological and psychiatric practice that are still so commonplace. If your spirit is flagging these books might help you get out of bed in the morning.

Whitaker's *Anatomy of an Epidemic* builds on his earlier book *Mad in America* (Whitaker, 2002). He is a campaigning scientific journalist. It is a good read, and is well argued and referenced. He builds a compelling case for the damaging long-term effects of psychotropic medications. He does this by asking whether our drug-focused paradigm of care is working for individuals and society, whether the chemical imbalance story is true, and how psychiatric medications shape the long-term course of major mental disorders.

To answer all these questions he reviews the scientific literature. He majors on the lack of long-term studies, the misinterpretation of relapses when medications are withdrawn, the systematic misrepresentation of trial data, and the WHO literature indicating better outcomes in psychosis in the developing world. His chapters on the epidemic spreading to Children are particularly alarming. Political science rather than psychology surely better explains the 3.5 million American children currently on stimulants for 'ADHD' and the equally exponential rate of increase of their prescription here.

In his final chapter on 'Blueprints for Reform' he says that the 'psychiatric establishment has failed to tell us that the drugs worsen long-term outcomes'. He advocates a much more evidence-based, cautious and questioning approach to the use of all psychotropic medications and a return to models of care that promote alternative forms of non-drug care. His analysis places too much responsibility on the iatrogenic effects of medication to explain the dramatic increase in long-term disability claimants due to mental health difficulties. He doesn't attempt to address or weigh the associated societal and political factors in his equation and this weakness is reflected in his suggested solutions. See his website (www.madinamerica.com) for more details of these.

If Whitaker's analysis is correct and I suspect much of it is, he is highlighting a significant multibillion tragedy and scandal and it is puzzling why his book hasn't thus far had a higher profile in the UK.

Demedicalising Misery is a very different sort of book. A significant number of its contributors , such as Irving Kirsch and Joanna Moncrieff are cited by Whitaker. The book has its roots in papers presented at conferences convened by the University of East London with the Critical Psychiatry and Hearing Voices Networks. The nineteen chapters are short and pithy and give a good introduction to the work of many of key crit-

ical figures who are challenging received wisdom in current psychological and psychiatric practice. I particularly liked David Harper's chapter on the Social Context of Paranoia. This is a must read given the levels of fear currently prevalent in public services. He conceptually unpicks paranoia and argues for more attention to experiences of trust mistrust and suspicion. He also helpfully places paranoia in the context of falling societal levels of trust. Sami Tamini, a leading critical child psychiatrist, has a great chapter on 'Medicalising Masculinity'. This is also a must read for those who want to make sense of the ever rising tides of 'Autism' and 'ADHD'. Lucy Johnstone has a strong chapter 'Can Traumatic Events Traumatise People? Trauma, Madness and "Psychosis"', reviewing Read's work on the links between trauma, child abuse and madness. She argues for trauma informed services. My favourite contribution is from Mary Boyle: 'Making the World Go Away, and How Psychology and Psychiatry Benefit'. She unpicks the secondary gain and costs for clinical psychology of converting experience to symptoms or disorders which means that 'research can be and is carried out using intrapsychic attributes without ever mentioning context and life experience'. She argues that our anxiety to be truely scientific has led to an over identification with the natural and biological sciences. We talk biopsychosocial but our science and practice priviledges the biopsycho.

There is lots more of real merit in this book. It is required reading for all who are wrestling with the regressive and reductionist components of Care Pathways and their associated payments and will be very helpful to anyone in urgent need of a complacency monitor.

Both books make an important background contribution to the debates about our collective response to DSM V, our disciplines strategic alliances and direction of travel, and ability to speak out, and whether and why, as Richard Hassall and John Clements have argued, ' clinical psychology has lost its way'.

Further reading

Hassall, R. and Clements, J. (2011) Clinical Psychology getting lost? Accident strategy or symptom? *Clinical Psychology Forum, 217.*

Moncrieff, J., Rapley, M., & Dillon, J. (2011). *Demedicalizing misery: Psychiatry, psychology and the human condition.* Basingstoke, Hampshire; New York: Palgrave Macmillan.

Whitaker, R. (2002). *Mad in America : Bad science, bad medicine, and the enduring mistreatment of the mentally ill.* Cambridge, MA: Perseus Pub.

Whitaker, R. (n.d.). *Mad in America.* Retreived 19 December 2011 from www.madinamerica.com.

Whitaker, R. (2010). *Anatomy of an epidemic : Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America.* New York: Crown Publishing Group.

The Social Cure: Identity, Health and Well-being by Yolanda Jetten, Catherine Haslam and S. Alexander Haslam (Psychology Press, 2011)
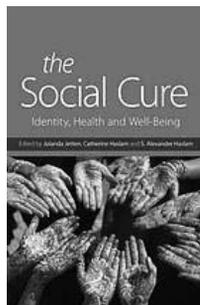
Reviewer Tony Wainwright, University of Exeter

The preface to this book begins with a quote from the famous psychologist Clement Freud:

Clement Freud observed 'if you resolve to give up smoking, drinking, and loving, you don't actually live longer; it just seems longer'. In recognising that time seems to pass more slowly when we are unhappy or depressed, Freud alludes to the fact that seemingly unhealthy activities (ones that are often indulged in the company of others) can paradoxically be better for us if they are the basis for fulfilling social life.

Social identity theory, on which this book is based, has its origins in the work of Tajfel (Tajfel, Billig et al., 1971) and the minimal group studies. These showed that people

would identify with an in-group, simply on the basis of being allocated to that group with some randomly assigned minimal characteristic. The studies that emerge from this finding are wide ranging and have been accumulating a substantial evidence base over the years. I became interested in this area again recently when considering the way we were teaching leadership to clinical psychology trainees. Leadership has become one of the key areas in professional training, and while this has a fashionable aspect to it, it also encompasses something of central importance for the our professional identity.

When reading about leadership there was much material describing characteristics of individuals who were 'good' leaders but none of it quite make sense to me. A good deal of it seemed to be concerned with urging individuals to behave in particular ways but there was virtually no theory behind it or indeed much of an evidence base. Then I came across one of Alex Haslam's other books, (Haslam, Reicher et al. 2011) The New Psychology of Leadership (which I downloaded to my newly acquired Kindle) and read with great interest as it described the use of social identity theory and the associated empirical research in understanding the way leadership emerges from social relationships. In addition social identity theory linked up with another of my interests, namely Social Role Valorization theory from the work of Wolf Wolfensberger (Wolfensberger 1998) which provides a way of improving the lives of people at risk of social devaluation.

The book is divided into five sections covering social identity and a particular theme: part one deals with health and well-being; part two with stigma and coping; part three with stress and trauma; part four recovery and rehabilitation; and the final concluding section about next steps in theory, practice and policy.

The approach taken in most of the chapters is to review the relevant literature and propose ways in which the existing understandings of the link between social identity and various aspects of well-being and health can be translated into improved clinical delivery. It is extraordinarily wide ranging covering, for example, the positive impact on joining an online self-help group for people with dementia (Clare, Rowlands et al., 2008) to the psychological impact of extreme events during the Kosovo conflict.

One of the striking things that comes from reading this book is the general lack of attention to social identity as it relates to health in much of the contemporary health policy. For example, when there is discussion about social relationships these may be treated as being one dimentional – that is, if you count the number of people someone sees it will give you an idea of how good their social life is. We all know that this cannot be true, and the way we relate to groups (the 'we' rather than 'I' aspect of our lives) is crucial. Some relationships are healing and others are toxic.

If you are a practising clinical psychologist, you won't regret reading this book.

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Wolfensberger, W. (1998). A brief introduction to Social Role Valorization as a high-order concept for structuring human services. Syracuse, NY: Syracuse University.

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