Aspire Ψ

the path to clinical psychology

www.ClinPsy.org.uk

Issue 1 • Feb 2008

The Big Debate: Diversity

A-Z of clinical psychology

Inside the mind of a selector

First steps on the psychology trail

A week in the life of a clinical psychologist

Welcome from the Editor

Welcome to the first ever issue of Aspire, the e-magazine for those on the path to qualifying as Clinical Psychologists. The magazine is produced in association with our website: **www.ClinPsy.org.uk** which contains much more information on this topic. We hope to bring you articles and interviews that will be of interest to undergraduate students of psychology, graduates in psychology, those working in psychological posts like Assistant Psychologists and Graduate Mental Health Workers, those doing psychological research, those doing their Doctorate in Clinical Psychology and those who are qualified and working in the profession.

The editors of the magazine and administrators of the forum are qualified Clinical Psychologists in different specialities of work. We are ably assisted by a team who represent all aspects of the path to qualifying, including academics, clinicians, Assistants, Trainees and other qualified staff, so we are very confident about the quality of the information we provide. The forum is non-commercial, non-profit making, and has no allegiances, which we think makes it an independent source of reliable information. However, we are always open to feedback and new ideas, and we welcome contributions from a wide spectrum of contributors. So why not respond or join in?

This magazine is designed to contain a taster on many different topics, and we hope it will follow a similar pattern in each future issue. The contents include an interview with someone linked with a Clinical Psychology training course, a description of the job role of a qualified Clinical Psychologist, an article on one of the key aspects of working as a psychologist (in this issue: Supervision), a book review, a hot topic of debate (in this issue: Diversity), a short biographical piece by someone training or wanting to train in Clinical Psychology (to show how diverse our paths to the profession are), some reference information about the profession (in this issue, the basics of training in each branch of psychology and an A-Z of psychology lingo), letters to the editor and other little bits we thought might interest or amuse you.

The theme of this first issue is Diversity. One of the biggest challenges facing the profession is how we are going to ensure that we break away from our stereotype of being populated bymiddle class white women in their late twenties and thirties (with perhaps the exception of another stereotype where senior, management and academic posts are populated predominantly by white men approaching retirement!) and start to be more reflective of the diversity of the populations that we serve. However, the pool of applicants is predominantly of females, in their twenties, and the strongest features predictive of success are academic strength, vocational experience and having a clinical referee. Sadly, the figures from the Clearing House equal opportunities data show that the qualifications and GBR status of applicants in any of the minority groups (older, male, non-white, with dependents, not living in the UK) were lower than those in the majority groups. So, the successful candidates don't seem to reflect any active discrimination, but rather biases in the people who apply, compounded by more subtle differentiating factors. There is also a (in my view legitimate) bias towards people who have the most relevant experience, particularly those who have been supervised by Clinical Psychologists and worked in the NHS. We therefore need to address the issue much earlier in people's professional development path.

I'd like to think that the first step in that process is for a wider variety of people to be able to read about Clinical Psychology, and why this profession intrigues, challenges and satisfies those of us who are privileged to earn their living in this way. I hope this magazine proves to be just such a taster, and leads people to want to find out more, and that our forum is a good starting place for further discovery.

Dr Miriam Silver
Chartered Clinical Psychologist
Editor of Aspire

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Insights from the other side: Interview with a Selector

I had the opportunity to ask some questions to one of the people involved in selection for clinical training. However, like 'The Stig' on Topgear, I've promised to keep his/her identity anonymous…

Why be involved in selection? And why make tasks?
I've been doing it for a long time. I wanted to consider the interface between personal and professional style and judge those factors which might not come across in interview. A group task is therefore one aspect of a selection process, and I think it adds to the picture we get of applicants. It's not necessarily proven by evidence, but our feel is that it is a valid way of broadening what we look at. We think about the process of selection as an opportunity for people to present themselves well.

What makes a candidate stand out?

What does the task show you?
How people manage interpersonally, and balance showing themselves well and supporting others. It challenges people to think quickly and cope with pressure. All of these are skills that will later be used as a clinician.

How are courses addressing the issue of diversity?
With the increase of numbers we get a wider range of applicants and more diversity, and we hope that filters through in to who we select. We try to address diversity by being open to considering everyone, whilst also selecting people who are the best candidates. It is difficult where the pool of applicants is quite homogenous, but we would be really positive where an applicant had the qualities we seek, but was not the stereotype.

What advice would you give to applicants?
The element of competition and selection is very emotionally laden and can get in the way of people being able to say "this is who I am". People invest so much in the quest that it risks being so dominant that people's interests and personality get lost. Its cliché, but the best advice is to just be yourself.

What stands out about candidates in a positive way?
Combining being sensitive and powerful, having clear thinking, and humour. The ideal candidate has intellectual rigour combined with interpersonal skills.

What stands out for you as a caution?
An obsequious need to please, or a sense of putting on a show of how they think they should be, is something I'd see as a negative. Being brusque or egocentric in a way that shows them as aggressively dominant or lacking awareness of their impact on others would be the other one.

You've been on the side of interviewer a lot, how do you find it as an interviewee?
I've been asked a lot of odd questions, but mostly I try and wonder what they are looking for and try to tell them what I think. I try to avoid thinking how I want to present myself and just respond to what I am asked honestly.

Why did you decided to be a clinical psychologist?
I have a commitment to support people in developing a capacity to manage their lives productively. I enjoy working with like-minded people, doing innovative work, with a "can do" attitude.

Finally, what are the joys and frustrations of being a Clinical Psychologist now?
I love the clinical work. Its frustrating that so much else has become part of our role. It a balance between working directly and changing systems to reach the same aim. I get frustrated by red tape and over-monitoring. I can see the government want to monitor their investment but it diminishes the impact of the resources to have to do all of that, compared to just getting on and delivering.

A light-hearted look at…
Supervision in Psychology

Now I have had many a supervisor before, from the type that make you sweep the floor and empty the grease traps at fast food restaurants to the prestigious gown wearing academics. However, until I stumbled across the world of therapy I had hardly any idea what this type of supervision entailed, and I guess very few on the outside that know what it is either. Let me fill you in.

Now the job of the supervisor is to check what you are doing with your clients, your reason for doing it, and to keep you on the straight and narrow. So far, so good. However, supervisors in therapy can also focus on your own personality, what else may be happening in the therapy room, and can bring to the open things you had previously never considered to make you a better therapist. This would be the factory equivalent of your line foreman telling you to stop packing the lettuce and start talking about your role in the global agricultural economy. The first time you come across it, it can be a bit strange.

You are told supervision isn't therapy, but it has a similar flavour. It is time devoted to you and you get to talk about your work, your thinking and your practice. You also get to discuss any hunches you may have, or ask for advice. Ideally, in supervision you don't get told to quit talking, work faster, to do the graveyard shift at the last minute or have to put up with the trials and tribulations of your supervisor's useless son-in-law, which is where it deviates in comparison to supervision you may have been used to in other jobs.

Ideally, that is. Supervisors are never one and the same. Rather strangely, supervisors seem to be one of those things in life that are memorable because they fall into one of two categories; either really, really great super-heroes that genuinely care what you are doing, make an effort to look out for you, and make your work as smooth as possible, or figures of fear that go out of their way to provoke, upset or undermine you. I know of some supervisors that would inspire samurai-like loyalty in their supervisees, whereas others inspire the type of terror normally associated with Darth Vader. We have all heard tales of nightmare supervisors, like the one that made you retype that letter eight times before the original one was sent out, or the one that took you apart piece by piece when you did something wrong. However, supervision is often as much about what you bring to it as what your supervisor brings, and can be a tremendous source of professional growth.

FAQs

Q: What is supervision?

A: A time when you meet with a more experienced person, who is often your manager, to talk about how your job is going, and what you are doing with clients in therapy, or how you are progressing with the role requirements. It is a time to discuss your professional development, how you fit into the wider organisation, and to feel guided in your clinical work, as well as to pick up any management issues.

Q: How often should I get supervision?

A: Normally, for a graduate psychologist post (like AP or GMHW), this is around an hour per week of full-time work. For a qualified Clinical Psychologist the rate will decrease as you become more experienced, with an hour per fortnight being typical at Band 8a, an hour per month at 8b, and peer supervision and regional or strategic meetings often taking on this role for consultants.

Q: What is the structure and remit of supervision?

A: This is something that should ideally be contracted between supervisor and supervisee when they begin meeting, and reviewed periodically. Ideally supervision times should be regular, protected from interruption, and at a mutually convenient time and venue. It is typical for each party to bring items to put on the agenda, and for the supervisee to be responsible for highlighting cases that need discussion (it may also be in some roles that all cases are discussed at every supervision session). Over the course of a career a Clinical Psychologist will be exposed to many different models of supervision, and will learn the structure and type of supervision that feels the best match with their own style, and what they find useful to bring to supervision. This also shapes the type of supervisor we, in turn, become.

Q: Can I trust my supervisor enough to share personal stuff in supervision?

A: This depends on the nature of your relationship, and the supervision contract you have negotiated. It may be tempting to try to impress your supervisor by only presenting positive aspects at supervision, especially if you are thinking that your supervisor will be writing your reference down the line. However, the best supervision relationships are those in which a safe and trusting space can be created, in which anything relevant can be shared. Knowing the boundaries of your own competence and recognising the interface between personal and professional are skills that many supervisors value and try to cultivate, and would view positively. Discussion of your reactions to clients and the material they bring to therapy can highlight issues of transference and counter-transference, which can make you feel safer and more effective in your work. Therefore supervision is normally a good place to ask questions, and share any concerns.

Content of example supervision

- ***Setting agenda.***
- ***Case discussion: Discussion of possible ways forward with a therapy case that feels stuck, some reading recommended, personal impact of a client's disclosure and transference issues discussed, plus review of progress in other cases.***
- ***Management discussion: Progress review. Establishing targets for completion, presentation and write up of an audit, check of admin processes.***
- ***Service/CPD discussion: Hopes to develop new skills discussed, a potential training event identified, discussion of wider organisational change.***
- ***Confirm time and date of next meeting and what needs to be reviewed. Both parties sign supervision record, or notes of discussion in relevant case files.***

THE BIG DEBATE: DIVERSITY

Our staff writer, Dr Ian Barkataki explores the issue of whether we are limiting diversity in the profession with our traditional course selection methods

We all live in the 21st Century, and we all know from Benetton adverts and Sesame Street that we may not look alike and think different things, but deep down we are more similar than we maybe would care to admit. However, clinical psychology courses have been criticised for the homogeneity of the trainees they have recruited. Indeed a quick glance at the demographics from the Clinical Psychology Clearing House shows that the majority of the 2006 intake are; white (91%), female (86%), not disabled (96%) and aged between 20-30 years of age (82%). Nonetheless, several courses have expressed a commitment to recruiting from increasingly diverse backgrounds in order to represent and serve a wider range of communities. In this debate we look at the difference between this new drive for diversity versus the traditional way of selection.

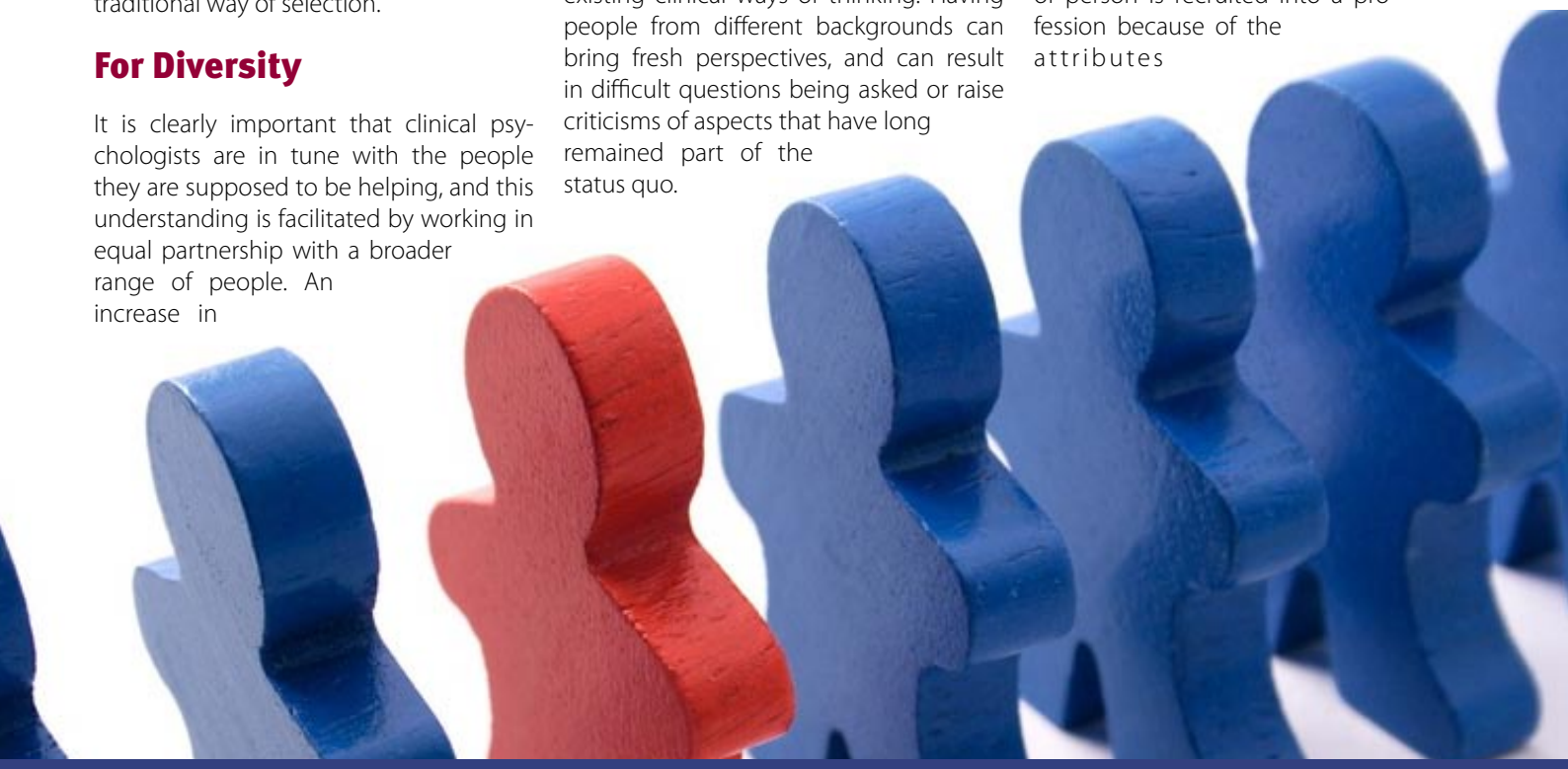
For Diversity

It is clearly important that clinical psychologists are in tune with the people they are supposed to be helping, and this understanding is facilitated by working in equal partnership with a broader range of people. An increase in the variety of backgrounds also assists in breaking down social barriers, be they of class, ethnicity, age, gender or sexuality. This is especially important in clinical psychology whose primary concern is based around understanding differences in various groups of people.

A wider mix of people in psychology as a whole will inevitably promote new ways of thinking. The resources people will bring from their various backgrounds could result in a blending of tried and tested methods with newer or more experimental approaches. Indeed witness the recent interest in mindfulness within therapy, (based on Eastern philosophies/ religions), or the acceptance of social constructionism (which originates from postmodernism), both of which add immensely to existing clinical ways of thinking. Having people from different backgrounds can bring fresh perspectives, and can result in difficult questions being asked or raise criticisms of aspects that have long remained part of the status quo.

Another beneficial effect of different backgrounds will be the various skill sets to the job increasing the versatility of psychologists and enabling better interdisciplinary working. If someone has a background, say as a psychiatric nurse, it will put them in a better position to empathise with other psychiatric nurses and appreciate some of the issues they face on a day to day basis (just as a Muslim therapist may be more attuned to the cultural context of a Muslim client).

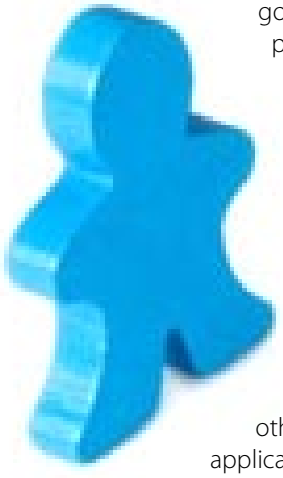
There is also something about diversity being linked with fairness. Sometimes it is important that a very specific type of person is recruited into a profession because of the attributes



they have are essential for that job. For example, it makes sense that those with better strength, agility and stamina are more suitable for a career in athletics. However, the skills required for clinical psychology (ranging from empathy and reflection to scientific understanding and managerial skills) don't lie with one particular group of people, and raises questions about how fair the current system is and how much it runs along the lines of an "old boy network"…

For Tradition

Whilst very few would advocate privileging one group over another, there are reasons why certain skews exist. Although it would be nice to have equal numbers of men and women trainee psychologists, in reality, the higher percentage of women studying psychology at undergraduate level and wanting to go on to a career in professional psychology means that trainees are more likely to be female than male (though historically this was not always the case). Similarly, many other potential applicants that would bring diversity to the profession opt not to pursue a career in clinical psychology for various reasons, be they cultural or circumstantial. It is hard to overcome such inherent inequity, and while it may be commendable of clinical training courses to encourage diversity, it may be pragmatic to accept that a certain degree of skewness is unavoidable, with the skew being imposed by potential psychologists themselves and occurring prior to the pool of applicants from which courses select, rather than being the product of any inherent prejudice.



Also there are many that still maintain that the traditional routes of entry (primarily via being an assistant psychologist in an NHS setting) are the ones that assure the greatest understanding of the job and ensure minimum standards of proficiency in clinical practice. This argument is based on the notion of it being necessary to witness and experience some of the work of a clinical psychologist first hand and up close to know exactly what they do before making the tumultuous, and (for the NHS) costly, journey of clinical training. Following on from this, there is also the feeling that those that have made the appropriate choices early on, and have made all of the necessary preparation specifically for a career clinical psychology by working their way up from psychology degree to assistant level deserve to progress onto training, when compared to people from other backgrounds who may be coming into the profession "from the outside". Although some may view this perspective as protectionist at best and at worst emotional, it is worth considering when thinking about the effort, sacrifices and uncertainties that many are faced with.

Currently the thinking on some courses is to encourage applicants from a wide range of backgrounds, so they can take diversity into consideration in a situation where two candidates are equal in all other instances. However, there are many concerned with the possibility of positive discrimination coming into play, which could lead to the reduction of standards in order to favour less represented groups. Such affirmative action schemes have been controversial in the US, where they have been used in college admissions. Instead of furthering the plight of the underrepresented they have given rise to anger and resentment. It is essential that this is avoided in clinical psychology because it undermines the efforts of existing trainees, and may raise feelings that they were chosen for their particular difference instead of any qualities they may have. Also there are worries that the current drive towards diversity will lead to the rise of tokenism, and the idea that courses will pay lip service to diversity by recruiting a few token minority group trainees, whilst not changing the underlying ethos of training.

A week in the life of...

A clinical psychologist in HIV and sexual health

By Dr Russel Ayling, Chartered Clinical Psychologist

I am employed by the clinical psychology service within the Infection and Immunity Specialty Group of a London NHS Trust. My team, which comprises nine clinical psychologists and one or two trainees at any one time, provides clinical psychology services to HIV medicine, genito-urinary medicine and the chronic fatigue service. I am contracted to work in the HIV and sexual health services, and my clinical sessions are split roughly between these. My week follows quite a regular structure, which is important as I work in three clinics across two different hospital sites in London.

Monday

Monday is a full clinical day in the HIV service, and I have six outpatient appointments spread across the day. My work in this service is broad, and I receive referrals from all members of the multidisciplinary team, typically the HIV physicians and specialist nurses. Referral reasons are broad, and may include any mental health presentation in our client group, all of whom are HIV positive. As one of two male psychologists in the team, I tend to specialise in gay men's sexual and relationship difficulties, but I also see people who are adjusting to their diagnoses, who may have problems with low mood and anxiety, and other psychological difficulties. A lot of our clients are not native to the UK, English may not be their first language, and there may be complicating factors such as poor housing, uncertain immigration status and other forms of social inequality. Our service also provides psychological assessment and intervention with to our HIV inpatient wards, for those being treated for more acute infections, and we take it in turns to be the 'ward psychologist' on a six month rotation. We provide neuropsychological assessment for inpatients and outpatients too, and this is a special interest of mine, so I see a fair number of these clients.

Tuesday

On Tuesday mornings I see two more patients in the HIV service, then in the afternoon, I run a male sexual function clinic, which is based in the sexual health service. I work with one of the lead psychologists in this clinic, and with the consultant physician for sexual health, we provide biopsychosocial assessments and interventions for men (and their partners) who are having difficulties with erections and early or delayed ejaculation. Demand is very high in this clinic, and we see a lot of Bangladeshi men, due to the ethnicity of our catchment. Every Tuesday afternoon, I see two new clients for assessment, and three existing clients for follow-up.

A week in the life...

Wednesday

Wednesday mornings are always CPD time, we have a full and varied programme through the month, and present and teach regularly. On the first Wednesday of the month, we have a clinical psychology team business meeting, with time for discussion and reflection afterwards. On second Wednesdays, the whole specialty group meets for clinical governance and audit presentations, and after this, the psychology team meet for a case presentation or clinical discussion. On third Wednesdays, the specialty group meets again for an academic and research presentation, and afterwards, our honorary neuropsychologist is available for case consultations. On fourth Wednesdays, the psychology team meets for an academic presentation followed by a systemic case supervision, using a reflecting team model. Occasional fifth Wednesdays are London wide research meetings within HIV/GU medicine. As well as this, the psychology team is involved in teaching medical students, trainee clinical psychologists, and members of the MDT about psychological aspects of HIV and GU medicine, as well as providing multi-professional journal clubs with the physicians and health advisors. Wednesday afternoons are my administration time, where I catch up with outstanding notes, letters and reports, as well as caseload management. I might also use this time to prepare for supervision; for a particular session, including formulation; for any teaching or presentations that I am due to give; or to mark my allocation of DClin coursework for the local clinical course.

Thursday

Thursday mornings begin with our weekly allocations meeting, where referrals for all the services we contribute to, are discussed and allocated. After this meeting, I receive clinical supervision before my sexual health clinic in the afternoon. I have a particular interest in gay men's sexual risk behaviour, and I run a risk reduction psychology clinic which runs at the same time as the dedicated gay men's sexual health clinic. We find that lots of gay men prefer to attend sessions later in the day, so my clinic runs between 1pm and 8pm, and I see six patients during this time.

Friday

On Friday mornings, I take time-in-lieu for the Thursday evening session, and Friday afternoon is my personal CPD time. Currently, I am attending a foundation course in Psychoanalysis, which runs every Friday afternoon. I am seeing one of my Thursday afternoon clients for psychodynamic therapy, for which I receive group supervision at the course. I am hoping to begin psychoanalytic therapy training proper in the next year or two, so this course is my first step towards this.

Reference Collection:
First steps on the trail.

By Dr Ian Barkataki and Dr Miriam Silver.

So you decide you want to be a psychologist, and you aren't too sure about getting there. Well, technically speaking at the moment in the UK, there is nothing to actually stop you calling yourself a psychologist right now (apart from your own sense of integrity) as the title isn't protected. But we will assume that you want to work as a chartered psychologist, which unfortunately is a little bit tougher, and is a title soon to be protected by the Health Professions Council.

The first thing you will need is a psychology degree that is recognised by the British Psychological Society (BPS). This can be a Bachelor of Arts (BA) or Bachelor of Science (BSc) degree. Such degrees will be classified as having a Graduate Basis for registration (GBR). This just informs you (and employers) that certain topics will have been covered during your degree, such as statistics and cognitive psychology. Don't worry about this too much as most degrees offered in the UK have this automatically incorporated as part of their structure, but its still worth checking before you sign up for a particular course. There is also an option to either sit a conversion course (for those that have a first degree in a different subject) or sit BPS exams (for those of you who come from overseas, or don't have GBR built in to your existing psychology degree) either of which will confer GBR. Universities vary in the content of their degree, but most have the same core elements, with optional extra ones you can pick depending on your own interests. Some universities also offer a placement year that involves working in industry, so you get to experience a certain area of psychology up close.

Although its great fun and you will learn a lot, the BA. or BSc. degree won't qualify you to practice psychology in an applied way, as it is purely an academic course and you will need to study further if you want to become a qualified psychologist. The next step is to decide which field of psychology you would like to work in. Psychologists tend to fall into one (or more) of the following fields:

Clinical Psychology

What is it? These psychologists work with people who suffer from problems such as mental illness, emotional distress, and challenging behaviour. They serve many different population groups including people of working age, older age, children and families, people with learning difficulties, people with physical health conditions, etc. They sometimes work with people with brain injury or neurological disorder in a speciality area of clinical psychology (neuropsychology).

What do I need to do it? You will need to do a 3-year Doctorate in Clinical Psychology before you qualify in this field. This is a funded (salaried) training, with academic and research requirements alongside supervised clinical practise. These courses are highly competitive and require a psychology degree at a 2:1 or better (or equivalent) plus relevant experience.

Counselling Psychology

What is it? Counselling psychologists work in similar settings to clinical psychologists. They also work across the lifespan and often work with people that seek therapy to enhance their lives, rather than a means to treat a particular mental problem.

What do I need to do it? A 3-year Doctorate in Counselling Psychology is what you will need before you can practice as a counselling psychologist. These are presently self-funded courses, with no salary.

Sport & Exercise Psychology

What is it? Sports psychologists often advise sportspeople and trainers about how to achieve better performance and motivation. They also work in exercise settings.

What do I need to do it? A 1 year full time or equivalent part-time MSc in Sports and Exercise Psychology (accredited by the BPS) as well as 2 years supervised experience with a chartered Sport and Exercise Psychologist.

Occupational Psychology

What is it? These are found in businesses, offices and other workplaces. They mainly work on making businesses more efficient, and increase their employees performance and satisfaction.

What do I need to do it? A 1 year full time or equivalent part-time MSc in Occupational Psychology (accredited by the BPS) as well as 2 years supervised experience with a chartered Occupational Psychologist. Sometimes you can qualify if you have 3 years supervised experience and are obtain a postgraduate certificate in Occupational Psychology.

Educational Psychology

What is it? Educational Psychologists work in schools to help students optimise their learning. They advise teaching staff where a child has emotional, behavioural or learning difficulties. They also assess children who require Statements of Special Educational needs. Some offer private assessments, or work in more specialised settings like residential special schools.

What do I need to do it? You used to have to do a PGCSE (teacher training) and then a masters degree in Educational Psychology, but this is changing to a 3 year doctorate in Educational Psychology.

Forensic psychology

What is it? These psychologists usually work within the legal framework. They work in prisons and secure hospitals often working with offenders and staff. They also work on assessing risk, rehabilitating offenders and offer consultancy with police and court services.

What do I need to do it? A 1 year full time or equivalent part-time MSc in Forensic Psychology (accredited by the BPS) as well as 2 years supervised by a chartered Forensic Psychologist.

Health psychology

What is it? Health psychologists are involved with health promotion and also with coping with long term illness. They can also advise healthcare staff (e.g. doctors and nurses), about working with clients. They sometimes work with supporting families and carers of those with illnesses.

What do I need to do it? A 1 year full time or equivalent part-time MSc in Health Psychology (accredited by the BPS) as well as 2 years supervised by a chartered Health Psychologist. There is also a Ph.D doctorate in Health Psychology route available (3 years usually).

Teaching & research (academic) psychology

What is it? These are the lecturers, teachers and researchers of psychology that mainly work in universities. These are the fine folk that will have taught you whilst you were an undergraduate, and who publish many of the papers you read in journals.

What do I need to do it? Although there are many levels of psychology teachers, university level lecturers normally hold a research doctorate (PhD). These usually take 3- 4 years to complete, but there are no definite limits.

Several of these areas will be discussed further in future issues of Aspire. However, you can also go to* http://www.bps.org.uk/careers/areas/areas_home.cfm *for more information.

Although all of these areas are interesting, we at Aspire and on www.ClinPsy.org.uk will focus on clinical psychology (because that's the kind of people we are), so we will discuss issues about what you might find helpful to get on in this area. For example, we aim to discuss ways of getting relevant experience to get onto clinical training, and the roles of different professionals in mental health services, as well as government and media issues relevant to clinical psychology.

Book Review

Johnstone, L & Dallos, R (2006).

Formulation in Psychology and Psychotherapy: making sense of people's problems.

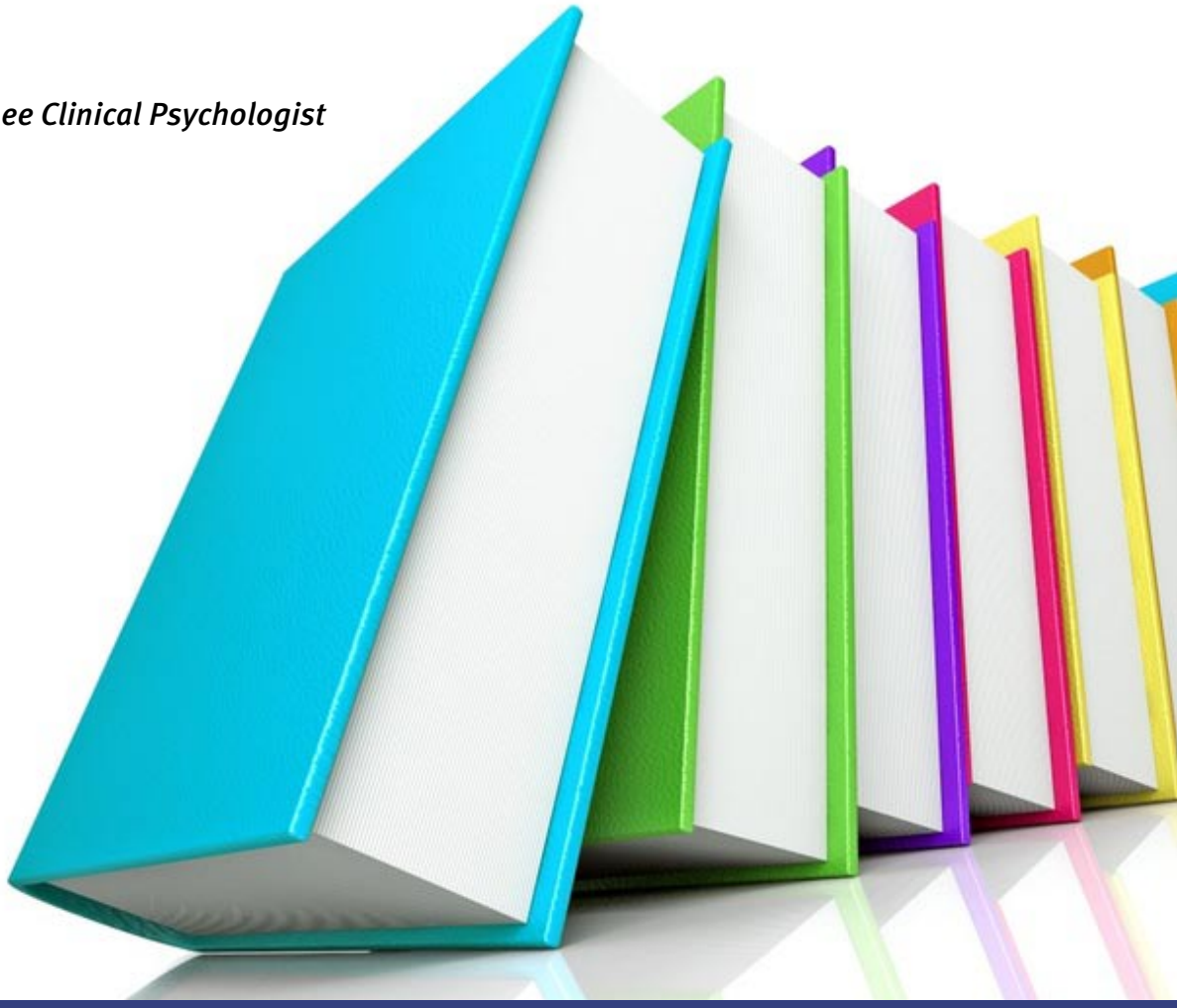
Routledge: London

This book has a clear vision, and is well executed through the numerous contributors. We are guided through formulations from the current and more emergent as well as the traditional core themes within psychology and psychotherapy; CBT, Psychodynamic, systemic, social constructionist, social inequalities, as well as two chapters on formulating integratively (which consider off the shelf integrative formulations, as well as ways of integrating more creatively). The chapters give us a well-rounded introduction to the differing philosophy that underpin each model of therapy, and pick out salient points to consider when formulating within that framework. Within each chapter there are one or two formulations, the cases that are considered remain constant throughout the book, which allows the reader to have a grasp of how each approach compares and contrasts.

The book considers the benefits and pitfalls of formulation, in terms of where it fits and its value within the role of the scientist practitioner model, and the specialist skills it involves, and takes a critical look at whether we really do have it right, in relation to reliability and validity. More importantly perhaps it addresses the pros and cons of formulations in the eyes of the client either through collaborative work (e.g. Cognitive Behavioural Therapy) or on presentation (e.g. Cognitive Analytic Therapy).

I was a little disappointed that both cases were not always formulated, sometimes only the young adult 'Jack' would be formulated, and not the difficulties of the child 'Janet'. This gave both an implicit and explicit message, and I wonder if we should be always moving towards global models applicable to all, or more focused that are applicable to few. I felt that the book would have benefited from a chapter on the Behavioural Model and functional analysis. That said, it's a readable little book that almost holds your hand while taking you through models and formulations, which come alive on the page with each exploration of the difficulties faced by Janet and Jack. It is strong in presenting theory as well as its application. I wouldn't hesitate in recommending it to anyone working, or wanting to work, therapeutically. It would also be accessible to undergraduates.

Caroline Taylor – Trainee Clinical Psychologist



Career Shifter

Why I really really wanna be a Clinical Psychologist

By Helen Galliard

Unfortunately being a philosophy postgraduate doesn't really equip you particularly well for the world of work. I had originally gone to university to study psychology, a far more practical discipline, but after 2 years I was sidetracked by the lure of discussing such fascinating theories as free will, morality and the possibility of my brain being manipulated remotely by an evil scientist. My degree allowed me to go on to do a MPhil in philosophy, focusing on artificial intelligence, sidestepping the need to get some sort of 'real' job and involving vast amounts of coffee - necessary to stay up all night programming computers to say hello to me. Once I had entered the real world, I worked as an editorial assistant and then as an editor. Fast forward 8 years and I am now a project manager in academic publishing with aspirations of one day being a clinical psychologist.

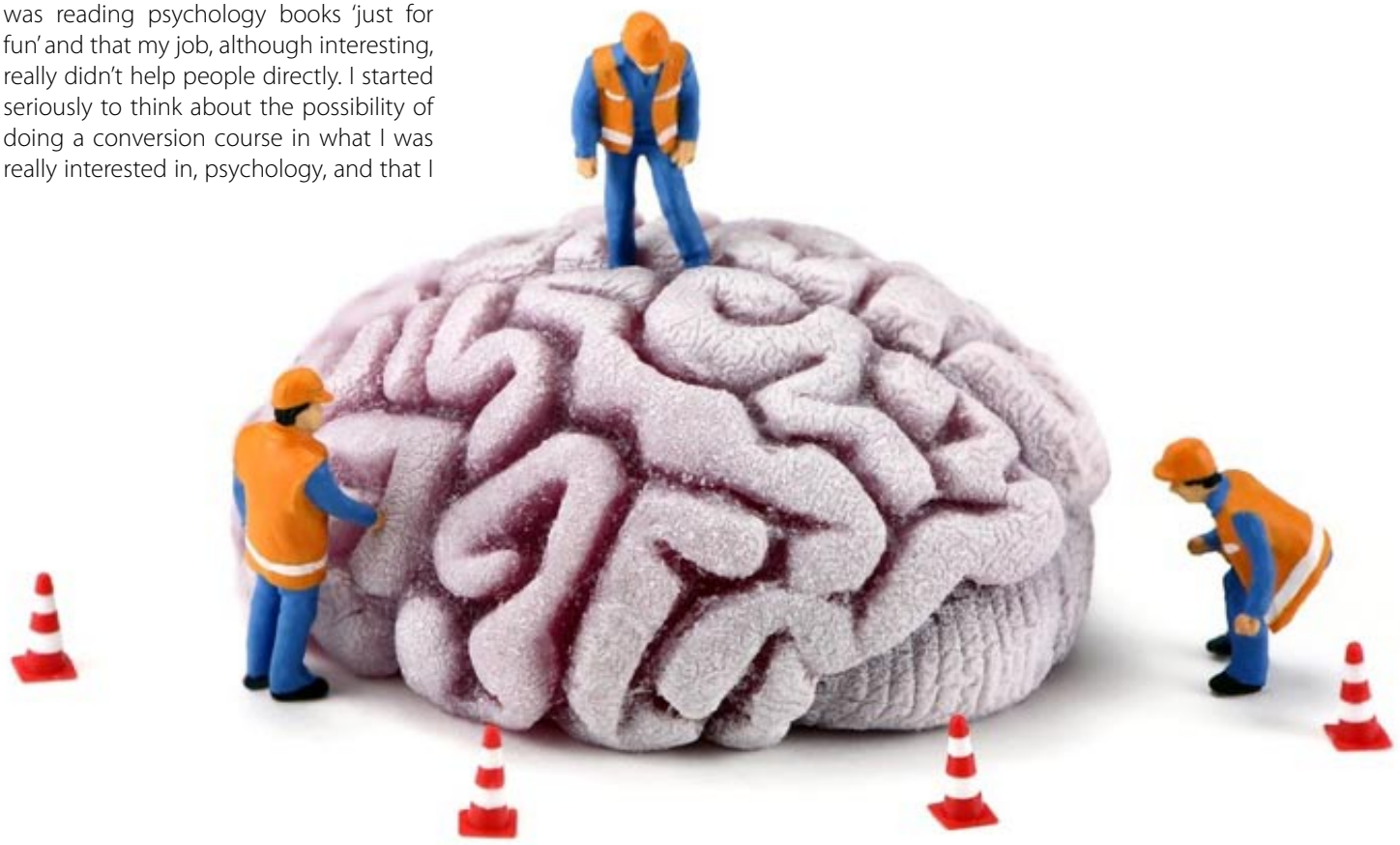
The turning point came after I realised I was reading psychology books 'just for fun' and that my job, although interesting, really didn't help people directly. I started seriously to think about the possibility of doing a conversion course in what I was really interested in, psychology, and that I might one day enable me to help people with mental health problems.

I suppose the other related factor is that my father is a clinical psychologist, I have memories of him bringing home IQ tests for me to play with when I was little! It also has the great advantage of having access to his past issues of the Psychologist and all of his clinical psychology books. I am also going to be able to rely on his advice and possibly even one or two contacts!

I do also have a vested interest in all of this, after all don't they say that psychologists often focus on areas relating to their own personal history! While I was at university I suffered from a period of anxiety issues and panic attacks - so one of my psychological interests is practical ways of dealing with anxiety disorders. For me one of the things that has helped over the years since I graduated is yoga. This interest has culminated in becoming a yoga teacher and I really enjoy teaching people practical ways to help deal with stress, this too has led me to re-assess what it is I want to do with the rest of my working life.

Now, I am fairly realistic about this path that I am embarking on. Just reading about clinical psychology and the path to training can be demoralising, but I think that at the very least I will end up working in mental health in some capacity even if this doesn't end up in the 'holy grail' of a place on a DClinPsych training course, although that is my ultimate aim. So it is fitting that this newsletter is called Aspire!

Currently, I have just started my conversion course and am about to start volunteering, so I hope I will soon be able to fully participate in the community of those on the way to becoming a psychologist.



the A to Z of clinical psychology

Any field of endeavour has its own jargon, and clinical psychology is no different. But fear not, we at Aspire are here to guide you through those embarrassing "What is he talking about?" moments. For your easy reference we have come up with a list and brief explanation of some of the more common abbreviations and acronyms that are bouncing around. Don't think of this as a comprehensive encyclopaedia, but more of a brief introductory guide. **By Dr Ian Barkataki and Dr Miriam Silver.**

A

A4C/AfC
Agenda for Change. A scheme to modernise pay in the health professions (excluding medical doctors and dentists). This includes psychologists and led to the new bandings and job titles, see below

ADHD
Attention Deficit Hyperactivity Disorder, a highly marketed condition in which a person struggles to concentrate, is impulsive and overactive. Often treated with stimulant medication.

AP: Assistant Psychologist. Usually a psychology graduate post working under the supervision of a clinical psychologist, and the most traditional route of entry into the profession. Although there is no "standard AP" job, duties often include administering tests, doing client support work and liaising with other professionals, or conducting research and audit, when it may be known as an AP(R) post. APs are often given administrative and clerical tasks to perform.

ASD
Autistic Spectrum Disorder, a condition identified by difficulties with social skills and inflexible thinking, it varies widely and is associated with other presumed neurological difficulties such as dyspraxia, sensory sensititivity, attentional difficulties, tics, epilepsy and learning difficulties.

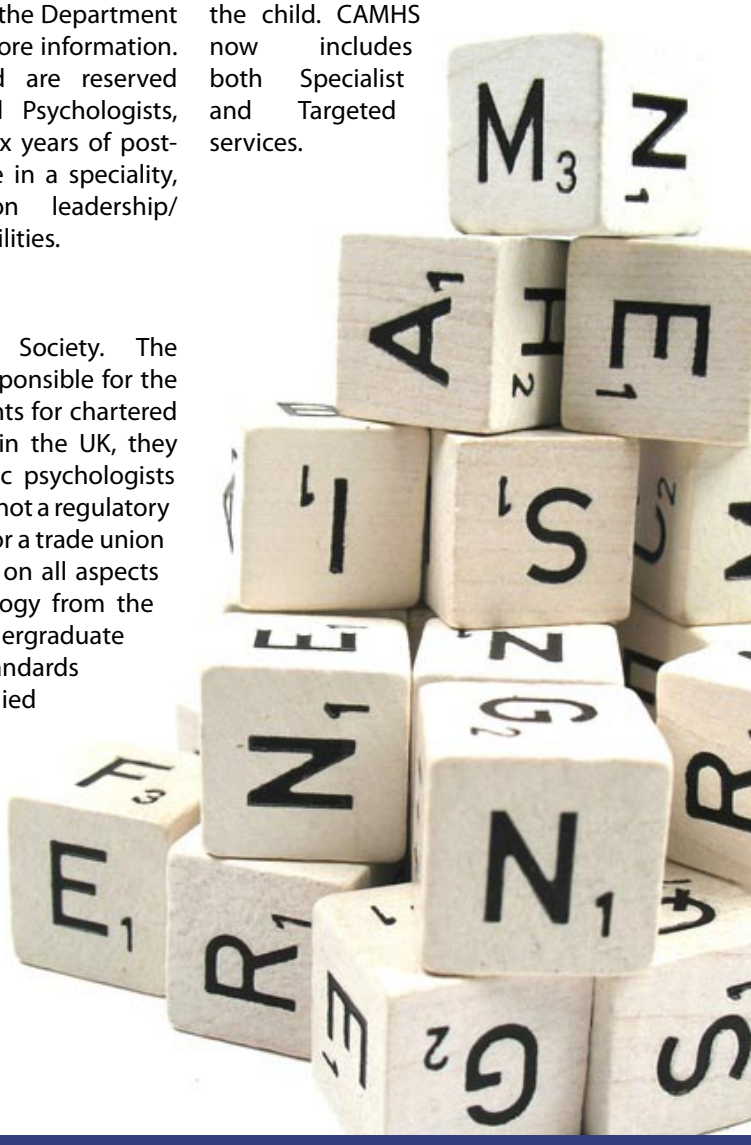
B

Band 5/6/7/8a/8b/8c/8d/9
These are pay scales relating to Agenda for Change. APs are paid on Band 4 and 5, trainee clinical psychologists are paid on Band 6 and newly qualified clinical psychologists start on Band 7 and work upwards. Exact salaries vary from year to year but you can check the Department of Health website for more information. Band 8c and upward are reserved for Consultant Clinical Psychologists, who have more than six years of post-qualification experience in a speciality, and have taken on leadership/ management responsibilities.

BPS
British Psychological Society. The representative body responsible for the professional requirements for chartered psychologists working in the UK, they also represent academic psychologists and students. Although not a regulatory agency, political forum or a trade union in itself, the BPS advise on all aspects of professional psychology from the requirements of the undergraduate degree and the standards of conduct for applied psychologists working with the public to the direction the profession takes in the future. Their role may change as the Health Professions Council (see HPC) begin to regulate Clinical Psychologists this year.

C

CAMHS
Child and Adolescent Mental Health Service, a multi-disciplinary service for children and young people, normally up to the age of 18. Work may be done with parents, children, families or the network around the child. CAMHS now includes both Specialist and Targeted services.



CBT
Cognitive Behaviour Therapy, based on the work of Beck this therapy model looks at the relationship between thoughts feelings and behaviour and uses behavioural experiments and a technique of challenging thoughts to treat the client's symptoms. Commonly used with anxiety and depression, but widely recommended for a range of disorders.

CP
Clinical Psychologist (usually), but can refer to Clinical Psychology the old name for the in-house journal produced by the Division of Clinical Psychology (See CPF).

CPF
Clinical Psychology Forum, the new name for the in house journal of the Division of Clinical Psychology. Not sure why such a radical re-branding was required, but there you go. Does sound a bit like something interactive on the internet, but is actually a white A5 booklet.

CMHT
Community Mental Health Team.

CPD
Continuous Professional development. A system of updating skills, learning new ones and staying aware of advances within the profession. A qualified psychologist has to submit a CPD record each year to get their practising certificate from the BPS (though membership of the BPS is not compulsory).

CPN/CMHN
Community Psychiatric Nurse or Community Mental Health Nurse. A type of nurse that specialises in mental health needs who works in the community or in clinics, rather than working entirely at a hospital or inpatient unit. They often work in community mental health teams and can provide support to clients in their home.

CTPLD
Community Team for People with Learning Disabilities.

D

DClinPsy/ClinPsyD/PsychD
Doctorate of Clinical Psychology. A (normally 3 year) programme of work and study that trains you to work as a clinical psychologist in the UK.

DCP
Division of Clinical Psychology. The part of the BPS that focuses on clinical psychology, and represents the interests of clinical psychologists.

G

Grade A
Prior to Agenda for Change this was the banding for non-consultant clinical psychologists (now bands 7, 8a and 8b).

Grade B
Prior to Agenda for Change this was the banding for consultant grade clinical psychologists (now bands 8c, 8d and 9). To be appointed at this level requires a minimum of six years post qualification experience in a specialty, leadership or management responsibility and an interview with 2 BPS assessors.

H

HCA
Health Care Assistant. A support worker who works very closely on a day-to-day basis with clients usually in an in-patient facility.

Highly Specialist Clinical Psychologist
AfC term for more experienced, but non-consultant psychologists, matched to bands 8a and 8b.

K

KSF
Knowledge and Skills Framework. A system of assessing various skills and competencies in different clinical roles, and apportioning pay accordingly. Linked with Agenda for Change.

M

MDT
Multi-disciplinary team. A team with different types of professionals in it, such as nurses, doctors, social workers, psychologists, OTs, etc.

N

NA
Nursing Assistant.

NICE
National Institute for Clinical Excellence. A government body that publishes guidelines for the treatment of various conditions, mainly on the basis of research and other clinical evidence. However, given their recent emphasis on CBT I suspect they would recommend using it to unblock a sink.

O

OCD
Obsessive Compulsive Disorder, an anxiety disorder where the person gets strong thoughts that make them enact rituals to feel better, such as washing, checking or repeating actions.

OT
Occupational Therapist.

P

PD
Personality Disorder. A dysfunctional pattern of relating to people, typically learnt from an abusive childhood. This diagnosis is controversial as it relates to legislation that can potentially imprison risky people who haven't committed a crime.

PLD
People with Learning Difficulties (generally, people in the bottom 1-2% on intelligence testing who also have difficulties with daily living skills)

PhD
Doctor of Philosophy (usually a qualification achieved by innovative independent research over 4 or 5 years)

Preceptorship
The name given to appointing a newly qualified Clinical Psychologist on Band 7 of AfC, with a commitment to raising this to Band 8a after two years.

R

RA
Research Assistant

S

SHO
Senior House Officer (a doctor who is beginning to specialise)

Specialist
A term applied to the core multi-disciplinary mental health service, which requires a referral from a GP or certain other professionals that meets specific criteria. For example, in Children's mental health services, Specialist or Core CAMHS is the main team in each locality that offers therapeutic services for children and families affected by emotional, behavioural or mental health issues.

Specialist Clinical Psychologist
AfC term for less experienced clinical psychologists, matched to band 7 (see also Preceptorship).

SpR
Specialist Registrar (a doctor who has specialised and is training to be a consultant)

SOE
Statement of equivalence, approval from the BPS that a foreign or non-standard qualification is equivalent to standard British qualifications and can lead to chartered status.

T

Targeted
Mental health services aimed at vulnerable groups. For example Targeted CAMHS services may proactively seek out children and families such as those with learning disabilities, those who are Looked After or adopted, refugees, those who are seeking asylum, travellers, etc.

Tiers
Levels of service delivery. Tier one is generic/universal primary care professionals like GPs, teachers, health visitors. Tier 2 is single mental health professionals at an accessible locality, like a practise counsellor or GMHW or a school nurse. Tier 3 are multi-disciplinary teams like CTPLD, AMHT, or CAMHS. Tier 4 are inpatient or highly specialised services, such as a high dependency team, eating disorders team, or a mental health unit. The idea is that each progressive tier is more specialised (and expensive) but a smaller service, as it will be needed by fewer people. In newer lingo, Tiers 1 and 2 may also be known as "Universal" and Tiers 3 and 4 as "Specialist".

U

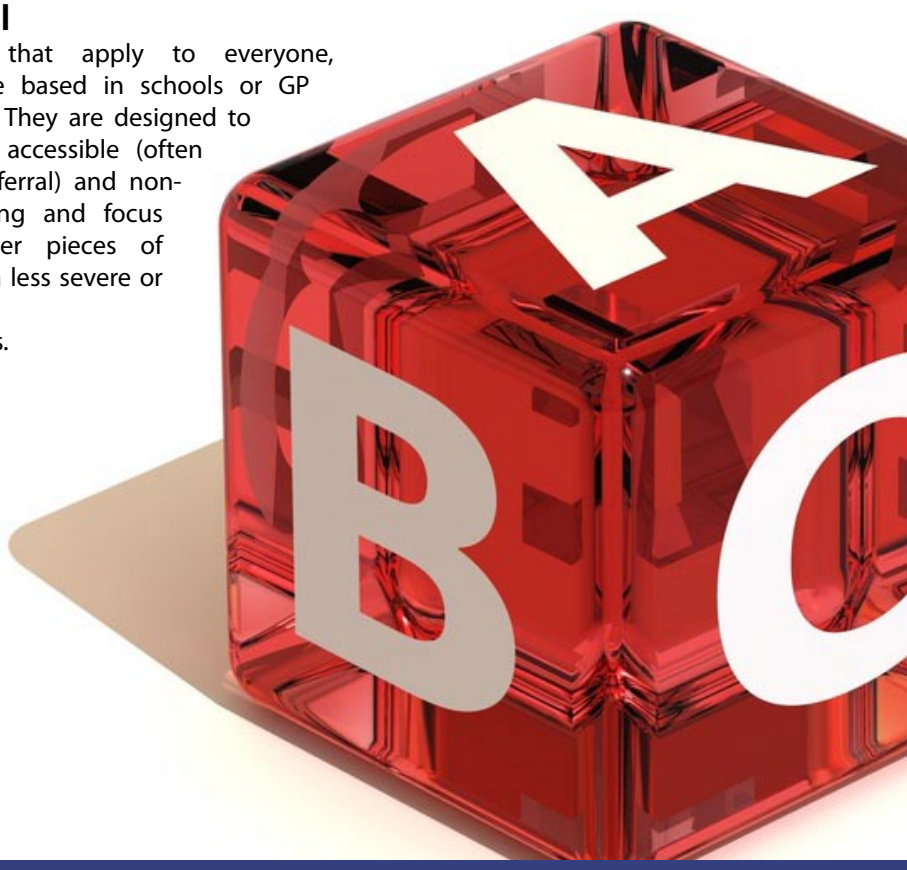
Universal
Services that apply to everyone, like those based in schools or GP surgeries. They are designed to be local, accessible (often by self-referral) and non-stigmatising and focus on shorter pieces of work with less severe or enduring difficulties.

W

WAIS
Wechsler Adult Intelligence Scale, a standard intelligence test for adults that can only be administered by psychologists. Numbers or Roman numerals afterwards refer to the revision edition.

WISC
Wechsler Intelligence Scale for Children, a standard intelligence test for children aged 6 to 17 that can only be administered by psychologists. Numbers or Roman numerals afterwards refer to the revision edition.

WASI/WORD/WOND/WIAT/WMS
Other Wechsler standardised tests. The WASI is the Abbreviated (4 subtest) Scale of Intelligence, the others explore literacy, numeracy, achievements and memory respectively.



News and Views

The latest from Aspire and www.ClinPsy.org.uk

www.ClinPsy.org.uk

It is now 9 months since we first opened the doors to www.ClinPsy.org.uk in that time it has grown into a thriving community. We now have over 1000 members and continue to grow steadily, with over 5000 page-views per day. There is also a growing pool of content and discussion, including 160 articles answering the most frequently asked questions about Clinical Psychology in our Wiki section, constantly updated discussions in our forum and regular clubs to critique research articles and other live content. So, if you haven't seen it yet why not take a look around? If you join you will be on the mailing list for future issues of Aspire and get to see it before anyone else!

Take part in our survey

Our plans are to continue to expand the content of the Wiki, and to add pages to the internet site (outside of the forum) with recommended reading, downloads, links and other resources. However we want to ensure that we continue to expand in a way that is most helpful to you. Because of this we are currently auditing www.ClinPsy.org.uk to see if we are meeting the needs of our members, and to gather feedback about the site and any improvements that our members would like. Please can you give us five minutes of your time to complete our user satisfaction survey by clicking on the link below.

In return for your participation, we are offering all members who complete the survey free entry into a prize draw to win one of three Amazon vouchers. Three survey participants will be drawn at random to receive the vouchers. The first prize is a voucher for £25, the second prize a voucher for £10 and the third prize a voucher for £5. Your answers will be kept anonymous, so please be honest in your responses. We are also very receptive to any comments, suggestions or other feedback about the site, which can be given via the survey link, or sent to any administrators, or emailed to clinpsyforum@gmail.com

http://www.clinpsy.org.uk/limesurvey/index.php?sid=96325&newtest=Y

Want to contribute?

We are getting ready to produce issue 2 of Aspire. If you have something you'd like to contribute please let us know. We'd love short stories or articles about people's jobs, experiences, path to training, book reviews, hot topics, anonymised case studies or discussion of controversies in the field. Also appropriate would be short summaries of new research or audit of broad interest. Submitted articles should be pitchedtowards an intelligent lay person, be no more than 2000 words and contain no more than 10 references. To submit articles please use the link at the bottom of this page and let us know whether you'd like your name to appear with the article or not..

? The open question: Share your views

Does the government focus on evidence-based practise restrict us unhelpfully with regard to the range of therapies that are considered acceptable to deliver? Post your response on the forum, or email clinpsyforum@gmail.com

News and Views

The latest from Aspire and www.ClinPsy.org.uk

A letter to the editor

Dear Miriam,

My teenage daughter wants to be a clinical psychologist, that's where the problem starts. We've been told by her school that next year she needs to get some experience of the job she wants to do but we are getting nowhere as she is only 15 and we are being told that she has to be 18 to get any sort of psychology experience!! She's a star pupil, getting good marks, well liked by her teachers and she even mentors younger children. We are desperate for some useful advice, can you help?

Regards, John.

Dear John,

You can read on our forum at www.ClinPsy.org.uk all about the path to training in clinical psychology - its a long one, and you can't rush it.

If she wants to be a psychologist then she will need to look for a work experience placement that brings her into contact with people who might use psychology services, like people with mental health problems, people with learning disabilities, people with dementia, children with emotional or behavioural problems. There isn't really any chance that she'll get experience with a clinical psychologist - I get offers every week of psychology graduates wanting voluntary work placements that I have to turn away - so she will have to think more broadly. That isn't specific to her, it is just the way the profession is, and reflects the level of competition at each stage. Even if that wasn't the case, in my view it simply wouldn't be appropriate to let a school student sit in on any form of therapy anyway.

If it helps any, I did my work experience (years ago) in a special needs school. She could also approach residential homes, day centres, mental health wards, charities. If she joins the forum and asks people about your specific locality, there might be someone local to you who could suggest useful places to contact. However, to be honest, the focus for her now needs to be to get good GCSEs and then good A levels to get into a good degree course (psychology at a traditional university normally needs 3 Bs). Once she is on her degree she can try to pick up some care experience, but its really only as a graduate that you can do any work that is actually related to psychology/ therapy.

If this is her aim for the future, I wish her luck with it. She's welcome to join the forum and learn more about it, but she will also need to be patient and enjoy the journey ahead!

Best Wishes,
Miriam

Caption competition

"Due to the drop in the average age of clinical trainees, courses had to resort to different training materials"

Spatch

If you want to suggest a caption for our next image, please look on the forum