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THE INAUGURAL ISSUE

Service User
Experience

Reflections
from the field

Threats to
Sustainability

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FOREWORD

A Beginning...

We're delighted to introduce the first edition of Clinical Psychology Today.

Like many such initiatives it began with quite a simple idea. We wanted to create a forum where Clinical Psychologists throughout the country could exchange views upon the challenges and joys of this work.

We know that the science and practice of Clinical Psychology involves not only the incremental accumulation of knowledge from empirical research but also the ethical consideration of how such knowledge can be used for the betterment of our communities. This latter task requires nuanced debate, scepticism and challenging rhetoric, a space for which can, at times, be absent in many journals. So, providing a place for such debate, as well as for the sharing of knowledge and experience, seemed important to us.

In one sense, therefore, this aim of creating a forum for dispersed Clinical Psychologists to talk together, is a simple and relatively uncontroversial one. On the other hand, we know from social research and from political movements that the very act of allowing people to communicate with each other can itself be a radical act.

Therefore, we're pleased that this first edition includes papers that touch upon the diverse challenges of an applied practitioner role. This edition has empirical research, pieces that debate contemporary issues in our profession, and reflective pieces on the lived experience of this work. We're particularly pleased that the authors of these papers range from Assistant Psychologists and Clinical Psychologists-in-Training, to Staff and Senior Clinical Psychologists and also include Principal and Director-level Psychologists. In this, we hope we capture some of the diversity of experience and knowledge of our broad community.

Particular thanks need to be given to Michelle Griffin-Doyle, who's tireless and creative work brought all of this together. We are indebted to her and to Kady Francis for her work on the online versions.

Finally, CPT is nothing if not a collective initiative, and as such we actively encourage input – see the “notice-board” to find out more on the many ways you can become involved!

With thanks,

Edition Editor and Deputy Editor: Pádraig Collins & Sean Foy.

SIX THREATS TO THE SUSTAINABILITY OF CLINICAL PSYCHOLOGY IN IRELAND

PÁDRAIG COLLINS AND SOPHIE GALLAGHER



ABSTRACT

This article explores the recent and significant growth in Clinical Psychology numbers in Ireland and abroad. It then explores the challenges that may exist around sustaining such growth. It also explores potential solutions to such arguing that not attending proactively to these difficulties might result in the current number of Clinical Psychologists in the Irish workforce representing the ‘high water mark’ of Clinical Psychology in Ireland.

INTRODUCTION

In a seminal paper David Pilgrim¹ set out the “6 threats to the sustainability of Clinical Psychology” highlighting profound philosophical and practical threats he felt the profession then faced (see Table 1). If the growth in numbers employed in Clinical Psychology is any metric of its strength, then the subsequent decade indicated that the profession either overcame or was not impeded (at least as of yet) by such issues. The following analysis of Clinical Psychology numbers would imply, however, that Pilgrim’s warning may yet prove prescient. This paper expands on these concerns and explores those specific to the

challenges of Clinical Psychology in Ireland.

Table 1: Six factors undermining sustainability of Clinical Psychology¹

Six factors undermining sustainability

- The lack of a stable consensus about psychological knowledge
- The contradictions of scientific humanism
- The petard of evidence-based practice
- The relative absence of legal duties and constraints
- The ambiguity created by numerical scarcity
- Individual therapeutic consultations amplify indeterminacy and undermine trust from others

The Boom in Clinical Psychology

Although exploring in any debt why Clinical Psychology might have flourished in recent times is beyond the scope of this article, the evidence of this phenomenon is presented.

Looking at figures from England (Table 2), between the early 1960s and 1970s, the number of Clinical Psychologists employed had almost trebled, albeit from a low base. By the mid- 80s it had almost trebled again and even between 2002 and 2009 an increase of 33% is recorded. Less striking, although still significant, are the increases reported for Scotland.

Table 2: Number of Clinical Psychologists in England and Scotland until 2009²⁻⁶

England	Scotland
1948: "A handful"	1950: 10wtes
1962: 198 (England & Wales)	
1973: 585 (England & Wales)	1976: 94wtes
1988: 1500 wtes (England)	1983: 158wtes
2002 : 4850 wtes (England)	
2009: 6463 wtes (England)	2009: 537.7wtes
2002-2009: 33% increase	wte = whole time equivalent

A similar phenomenon is recently seen on the island of Ireland as evidenced by the figures presented in Table 3. In Northern Ireland we see a doubling of Clinical Psychology Workforce in just over a decade. In Republic of Ireland, a near doubling of Clinical Psychology posts is reported between 2002 and 2011.

Table 3: Number of Clinical Psychologists in Northern Ireland/Republic of Ireland⁷⁻⁹

Northern Ireland (wte)	Rep. of Ireland (wte)
	1970: 96 Psychologists form PSI
2003: 115*	2002: 375
2008: 164	2004: 471.2
2015: 232.6	2008: 647.34
	2011: 710.02

*calculated on the basis that the 2008 '164' figure is quoted as representing a 43% increase on 2003

The most striking example, however, may be that in Australia (Table 4). Even in the last 7 years we see a near doubling of the numbers of registered Clinical Psychologists across Australia (registration being required to work as, and use the term 'Psychologist' in Australia), from a very healthy near 4000 in 2010, to near 7500 in 2016.

Table 4: Number of registered wte Clinical Psychologists in Australia 1963-2016¹⁰⁻¹²

Australia: Registered Clinical Psychologist
1963: 41
2010: 3,907
2011: 4,523
2012: 5,151
2013: 5,965
2014: 6,716
2015: 7,028
2016: 7,481

In this context it might be reasonable to think that Clinical Psychology is a thriving healthcare discipline, one that is increasing at relatively unprecedented rates and, as a profession, has little to worry about. However, more recent figures from England and Scotland presented in Table 5 indicate that there might be some grounds for concern about the future growth of this healthcare discipline.

The slowdown and evidence of 'workforce decapitation'

Closer analysis of these figures indicate that the pace of growth appears to have slowed down internationally. While Scotland reports a still healthy growth rate of 22% between 2010 and 2016, this is a fall from the higher rates reported in previous decades. This slowdown is more pronounced in the English workforce numbers where we see growth of 5.8% between 2010-2016; barely above the level of population growth at that time (4%). Even in Australia (see Table 4), with significant increases in the number of registered Clinical Psychologists in recent decades, there is a notable decrease in

the rates of growth of Clinical Psychology workforce in the most recent years. Internationally, these reductions do not appear to be explicable solely in terms of economic recession (e.g. Scotland and England had similar economic downturns but vary significantly in their workforce growth and Australia did not enter into recession).

Table 5: Recent Clinical Psychologist Workforce Figures in Scotland and England^{13,14}

Recent Scottish Workforce Figures	Recent England Workforce Figures
2010: 578.2	2010: 6573
2011: 580.1	2011: 6538
2012: 592.7	2012: 6521
2013: 619.0	2013: 6678
2014: 674.1	2014: 6611
2015: 686	2015: 6690
2016: 707	2016: 6955
2010- 2016: 22% increase	2010 – 2016: 5.8% increase (2010 – 2016 population rose by 4%)

In England there are numerous anecdotal reports of ‘workforce decapitation’ (which refers to a reduction in the number of senior grade posts even while the overall workforce is growing) and this concern has received some evidential support. The detailed breakdown of workforce data provided by Scotland indicates that the number of consultant grade Clinical Psychology posts (band 8c) has fallen from 231 wtes in 2011 to 204.9 wtes in 2016 even though the overall workforce has significantly increased as per the figures reported on above. Detailed Irish data on this potential phenomenon does not appear to be easily locatable.

Lessons from history

Taking a broader socio-historical lens to understanding these phenomena we can see that many healthcare professions have similarly flourished in particular contexts but not always survived. In the 18th and 19th centuries, Lithotomists, Cataract Couchers, Herniotomists, Barber-Surgeons and Butcher–Bonesetters were flourishing healthcare professions, widely accepted as the experts in their field, largely sought after, and during certain periods, experienced significant growth in their numbers. Their ultimate

demise lay not in their technology and skills being rendered obsolete by scientific advances, but rather by their *roles* becoming increasingly subsumed under the remit of other rising professions, most notably that of medical doctors. Historically medics would previously have shied away from this work and even included in their Hippocratic oath a commitment to leave certain interventions to more skilled professionals – i.e. “I will not use my knife, not even, verily, on sufferers from stone [i.e. kidney stones], but I will give place to such as are craftsmen therein [i.e. lithotomists]”.¹⁵ However, medical guilds subsequently increasingly expanded the remit of their work and insisted that they alone could safely perform these interventions, contributing to the exclusion and ultimate demise of these previously thriving professions. In this historic context, there may be a usefulness in exploring those issues of relevance to the ongoing survival of the profession of Clinical Psychology in Ireland.

SIX CURRENT THREATS TO CLINICAL PSYCHOLOGY IN IRELAND

When Clinical Psychology’s position in Ireland is examined, at least six clear threats to the profession’s further development may be identified.

1. Isolation

Isolation may occur for practical reasons e.g. when a Staff Grade Psychologist is in position without access to the necessary support from a Senior or Principal Psychologist, or when Psychologists choose not to meet and liaise with each on an ongoing basis. The consequences of this may be both personal and political.

While Clinical Psychology, as a profession, continues to grow, there is evidence that many of the Psychologists themselves are not personally doing so well. Detailed Irish data isn't easily accessible but in the 2015 British Psychological Society Survey of Psychological Professionals¹⁶ (UK) 46% of Psychological professionals surveyed report depression, 49.5% report feeling they are a failure and 70% say they are finding their job stressful. Similar evidence emerged from the 2016 Unite union survey of Applied Psychologists¹⁷ with 73% reporting that over the past 12 months their morale was worse or a lot worse, and over a third seriously considered leaving their NHS posts in the last 12 months. The BPS Working Group on Health and Well-being in the Workplace¹⁸ emphasise that support from supervisors and managers is one crucial element in fostering such wellbeing.

Research from social psychology indicates that isolation can also have political consequences in that it significantly restricts a discipline's capacity to collectively mobilise and advocate on its own behalf. Haslam et al.¹⁹ argue that group identity not only needs to be established but also needs to be *maintained* through: having an awareness of the group, identification with the group, networks of contact, engaging in activities as a group, and working collaboratively for common goals.^{19,20} In the absence of such maintenance, group identity can atrophy. As a result, *"only those that identify together can mobilize together"*²¹ and therefore are successful in achieving their aims.

2. Relationship with New Roles

The development of new roles is inevitable in constantly evolving healthcare systems, partly due to ever increasing demands on healthcare services with limited resources. In Ireland we have seen a range of new roles emerge in the Irish Mental Health services such as the 'Team Coordinator', 'Network Lead Clinicians', 'Recovery Lead', 'Peer Support Worker Coordinator'. Each of these roles can be occupied by Clinical Psychologists. Internationally we see a similar broadening and diversification in roles occupied by Clinical Psychologists including those of the 'Responsible Clinician', 'Approved Clinician' and 'Approved Mental Health Practitioner' in the UK. While in the USA, certain Clinical Psychologists have taken on the role of prescribing clinicians prescribing psychotropic medication.²²

The diversification of traditional roles may bring with it an opportunity to reinforce or contest traditional power dynamics. Disciplines that do take up new roles have the opportunity to organisationally gain influence and those who do not may have their influence diminished. For example, the filling of the new Team Coordinator role almost universally by the nursing profession may naturally give rise to the development of team policy and team functioning that is influenced by a more bio-medical model (and nursing professional culture) rather than other influences.

3. Displacement

Clinical Psychologists have traditionally viewed their role and key competencies as expert psychotherapists, as experts in psychological assessment and formulation and in governance of psychological therapies. However, other disciplines are increasingly arguing that such roles can be adequately carried out without any input from Clinical Psychology.

In terms of the training of psychiatrists and nurses, there is an explicit reference to psychological formulation being a key element in the initial and ongoing training.^{23,24} In terms of the governance of psychological therapies, psychiatry and nursing disciplines are very explicit they can govern and oversee the provision of psychological therapies.^{23,25} The Certificate in Psychosocial interventions introduced in 2013 by the Office of Nursing and Midwifery Services Director, explicitly states that all nurses should be trained up in CBT and family work to thereby lead in the provision of psychological therapies as per Vision for Change. The training is devised without any Clinical Psychology input and specifically states that trainees should have clinical

supervisors while undertaking the training and these supervisors must be nurses, ideally nurses with psychosocial or psychotherapeutic training. This may encapsulate a model whereby a different discipline can be trained, governed and supervised in the provision of psychological therapy without any input from Clinical Psychology.

4. Increasing Demands

The fourth threat is one that may be self-evident, that of increasing demands. There is evidence to suggest that the demands on Clinical Psychologists are constantly increasing. Over 80 per cent of clinical psychologists surveyed in the Unite survey¹⁷ reported that their workloads had increased either 'a little' or 'a lot' over the previous 12 months. To add to this, not only had the workloads increased in volume, but also in the diversity of need. This may partially have arisen from a more aware and empowered service-using community, increasingly cognisant of the value of psychological input, seeking input for their loved ones and themselves.

It is questionable whether the traditional model of focusing primarily on providing one-to-one therapy in consulting rooms may be capable of appropriately meeting this increased volume of need. Failing to meet this need, however, may result in the senior healthcare management querying whether Clinical Psychology, as a profession, can adequately meet the needs of the community. In this way, the ultimate demise of Clinical Psychology may lie not in the skills being rendered obsolete as such, but in the role becoming increasingly subsumed under the remit of other professions who are more accessible to the service-using community.

5. Research

Research is undeniably one of Clinical Psychology's key assets. However, less than 10% of Irish Clinical Psychologists time is spent on research (both production and dissemination).²⁶ Furthermore, the research the discipline is engaging in rarely attends directly to pressing concerns of healthcare managers, including those around access to services, waiting lists, standardization and quality control. Consequently, it may not be surprising that healthcare

systems are not always accommodating of the wish to engage in research.

6. Service User Alienation

The final threat, and arguably the most concerning, is that of service user alienation. Ten years ago, service users felt that there was no psychology available within the state system and an individual had to go private²⁷:

"...if I want to get a bit of psychotherapy like I go to a psychotherapist privately...because I don't think I get that from the health service..."

A decade later, the evidence about what service users think about psychological services in Ireland is still not overly positive²⁸:

"Wanted access to psychological services but never happened"

"I am still waiting to see a psychologist – 18 months"

In addition, service users are picking up on the interdisciplinary rivalry and the tensions this gives rise to:

"Psychiatrists and psychologists don't listen to each other"

As mental health services are being increasingly encouraged to focus on greater service user involvement – "nothing about me, without me" - such as the 'Your service Your say' HSE complaints policy²⁹ introduced in 2015, then consequentially it might be vital that Clinical Psychology is seen as an important partner in advancing the goal of greater recovery-oriented services.

A danger may lie in the profession being

seen as remaining largely invisible or indifferent to long waiting lists or initiatives promoting greater recovery orientation. In such a scenario, it may be unsurprising if the service user movements ally with other disciplines to get their recovery needs met.

SIX PATHS TO SUSTAINABILITY OF CLINICAL PSYCHOLOGY IN IRELAND

Alternatively, there may be approaches that could help the continued development and sustainability of Clinical Psychology as profession. These may include:

1. *Returning to the Source*

Initiatives such as ‘listening exercises’ undertaken by the mental health division, and the increasing presence of ‘consumer panels’ throughout the country, may provide helpful ways to reconnect with, and learn from, the service-using community. Clinical Psychologists’ skills in qualitative methods or research may have particular relevance here. Clinical Psychologists have also been directly involved in the emergence of initiatives such as Recovery Colleges, Dialogues and peer support workers.³⁰ In so doing Psychology is publicly seen as being on the side of greater involvement and power for service users in their own care. Such partnerships may emphasise the importance of Clinical Psychology and not just psychological therapy is as a powerful motor of positive change.

2. *From Evidence Based Practice (EBP) to Practice Based Evidence (PBE)*

The second path to sustainability may involve a move from EBP to PBE. Traditionally EBP has involved applying international guidance on the use of particular therapeutic models for particular specific diagnoses. Given the critiques of the empirical validity of diagnoses in mental health^{30,31} and that of the limitations of the choice of therapeutic model in determining outcome^{32,33} it may be important that the profession returns to its empirical roots i.e. to systematically test out what is working for whom, in our own clinics, in our local area (e.g. by using standardised sessional outcome measures). Such an ongoing integration of clinical and

research skills highlight the unique skill-set the profession brings to this challenging work.

Such an approach may also allow a more genuine Recovery-oriented partnership approach whereby Clinical Psychologists learn from the individual service user what specifically is helpful to them and empirically monitor where such an informed approach is truly advancing their recovery goals (e.g. whether indeed ‘returning to playing hurling’ is the key ingredient for *this service user* in lifting mood and thereby advancing the recovery goal of ‘feeling able to return to work’).

3. *Actively Exploring Ways to Help*

The importance for any movement of continually ‘creating alternatives’ is well understood. From a social psychology perspective, the development of “cognitive alternatives” is absolutely crucial to change^{34,35}, meaning if we cannot imagine alternative ways of doing things it is impossible for such alternatives to occur. The discipline of Psychology can add our research skills to the process of exploring new ways of helping people in distress i.e. not only can the profession constantly trial new approaches but also evaluate whether these approaches actually work, and therefore can present a credible, empirically validated picture of alternative service provision.

Already in Ireland there is a range of new and novel practices being engaged in, such as models of stepped care (e.g. APSI³⁶), public engagement and community wellbeing festivals (Clonakilty and West Clare), and the concept of Recovery Colleges³⁷ or recovery story-telling.³⁸ Similarly there are moves towards the

development of crisis houses, staffed by mental health professionals, acting as crucial places (outside of hospital settings) people can go in times of mental health crises. All of these represent novel developments for supporting people in acute mental distress. Clinical Psychologists have played a role in the establishment of these initiatives and are crucially well-placed to evaluate and thereby further promote these ventures.

4. Broadening Horizons

When we study where numbers of Clinical Psychologists continue to expand, it is often in new domains of healthcare rather than traditional ones, such as areas with a community public health focus, or the expansion of psychology within the physical health domains. One recent example is from the Cambridge and Peterborough NHS trust where the number of Clinical Psychologists in physical health domains adds up to more than all Clinical Psychologists working in mental health and primary care across the rest of the trust. Continually exploring new domains wherein Psychology can be a positive influence seems essential to the profession's continued growth.

Similarly bringing psychological expertise into political systems (both local and national), especially in the development of national policy, allows the value of psychological work and insights to be publicly highlighted. This provides a practical and pragmatic way to use our research skills and knowledge to influence population-level change. In the UK a Behavioural Insights Team ('nudge' unit) was established to liaise and consult to the government on promoting positive health behaviour. A similar unit was set up in the USA, advising government how best to promote particular initiatives by applying behavioural science techniques (cf: the HPSI 'Health and Wellbeing' paper for a further exploration of these ideas³⁹).

5. Strategic Influencing

Progressing the values of any profession requires acquiring influence, which can be important within certain organisations, but also more broadly in influencing public opinion. In this latter regard, the profession actively seeking opportunities to form positive alliances with the media may

be essential to progressing the profession's values and beliefs (cf: David Coleman, Maureen Gaffney, Eddie Murphy).

Similarly, it may be important that the profession is not naive about the reality of power differentials in the management of healthcare systems, i.e. it may be important that the profession occupies senior positions in any organisation, if the values of psychology are to be promoted at the highest level.

6. Reconnection

This paper commenced with the concept of isolation and the damaging impact it can have upon the discipline and on individuals. Conversely, where Clinical Psychologists find ways to reconnect with each other there lies opportunity for personal and professional strength. Research indicates that a sense of shared identity can counteract stress in the individuals themselves, as well as secure support, challenge authority and promote social change.⁴⁰ Such reconnection may need to occur at a local and regional level (as well as national) with the formation of special interest groups, conferences focused on ideas of relevance to the profession, and in fora (journals, social media groups) wherein issues of relevance to Clinical Psychologists in Ireland can be debated together. If Clinical Psychologists can increasingly come together, identify together as a group, and collectively promote key shared values, then many of the threats outlined above may well be overcome and the profession's strength continue to grow.

CONCLUSION

Pilgrim highlighted many potential pitfalls for the discipline of Clinical Psychology and

this paper elaborates on similar threats to (and opportunities for) this profession in Ireland. The history of healthcare disciplines indicates that there were many disciplines who were flourishing in their own time, but whose demise derived from their inability to engage with social, political, and community demands that is required of all successful disciplines in this contested space of healthcare provision. A reluctance or inability in the profession of Clinical Psychology to evolve to meet these ever-changing demands may mean that we are currently observing the 'high water mark' of Clinical Psychology in Ireland. However, if Clinical Psychology heeds these historical warnings, it can move from potential hubris to actively reconnecting with the communities it serves and thereby vouchsafe its own future, at least for the time being.

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“NOT JUST A DISEASE WITH A PAIR OF LEGS”: PARTICIPANT AND PEER LEADER EXPERIENCES OF THE CHRONIC DISEASE SELF-MANAGEMENT PROGRAMME

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RUTH BUCKMASTER AND STEPHEN PATCHETT.



ABSTRACT

The Stanford developed Chronic Disease Self-Management programme (CDSMP) has been shown to improve self-efficacy, well-being and communication levels in people with chronic diseases, but little qualitative research has been conducted to better understand the unique experience of participating in the programme. The aim of this study was to explore the personal impact of the CDSMP for both participants and peer leaders.

INTRODUCTION

The Chronic Disease Self-Management Programme (CDSMP)¹ is a six-week course for patients with chronic illnesses developed by a team at Stanford University. It is a generic programme which allows for participation from

those with single and co-morbid conditions, and covers topics such as healthy eating, dealing with difficult emotions, fatigue, communicating with medical professionals, decision-making and problem-solving. A key aspect of this programme is that it is co-facilitated by at least one peer leader (a person living with chronic disease) who receives training alongside healthcare professional leaders. The CDSMP is currently delivered in various settings throughout Ireland; the present paper describes research which took place in a hospital setting that offers the CDSMP to patients as part of a joint initiative between the Departments of Psychology and Gastroenterology. We wanted to learn more about the experience of the patients who took part as both participants and leaders.

While quantitative outcomes for CDSMP participants have been widely documented, there is a relative lack of qualitative research exploring experiences of those involved and additionally, little is known about how peer leaders experience the process of training and group facilitation in terms of their own health management and psychosocial functioning. International studies have demonstrated the capacity for the CDSMP to positively impact health-related indices including self-efficacy, distress, self-

reported health, patient-doctor communication, self-monitoring, and insight over time.¹⁻⁵ Both self-efficacy in managing disease and self-efficacy in managing emotions have been shown to improve following the programme as well as reduced perceptions of social or role limitations.⁶ While such controlled quantitative studies speak to the efficacy of the programme, we wanted to enhance this knowledge base by exploring the individual experience from a service-user perspective, which is unlikely to be captured using standardised measures.

In one of the few studies to explore qualitatively the experience of participating in the CDSMP it was found that emotional control (that is, the ability to maintain optimism and deal with negative emotions) was increased by the experience of talking with and helping others in the group setting, and the aspect of group learning praised for the opportunity for members to improve and problem-solve together.⁷ As well as looking at participant experiences, the current study aimed to build on previous research by addressing the experience of the peer leader. It has been emphasised that the role of the leaders in the CDSMP is to facilitate group members in reaching their goals and to act as positive role models with similar backgrounds.¹ All leaders, both peer and healthcare professionals, are required to attend a dedicated leader training course which is facilitated by certified CDSMP master-trainers and uses a specific leaders' manual.⁸ Leader training involves trainees experiencing each aspect of the course, including creating and implementing their own action plans for sessions.⁹

It was also anticipated that insights could be gleaned from participants' experience of undergoing training alongside healthcare professionals, particularly as Catalano, Kendall, Vandenberg, and Hunter¹⁰ found that peer leaders were likely to feel inferior to healthcare professionals, leading to feelings of decreased self-confidence and rejection. We hoped to gain a better understanding of these dynamics so that we could better support our peer leader volunteers.

The Current Study

The current study was carried out at a large Irish teaching hospital where the CDSMP has been delivered since 2012. Previous research undertaken here has shown the

programme to be effective in enhancing the mood and emotional well-being of such patients.¹¹ By conducting this qualitative research at the levels of participant, peer leader post-training, and peer leader post-facilitation, we aimed to garner a broad-range perspective of the various aspects of this programme which are most likely to have consequences for the day-to-day lives of people with chronic diseases.

DESIGN

Participants

Participants were 12 people with chronic diseases who were involved at one of three levels (i.e. programme participants vs. recently trained leaders vs. leaders who have facilitated one group) with a CDSMP delivered by a large Irish teaching hospital. Information about the research was provided verbally and in writing during ongoing CDSMP and leader training courses; participants of recent programmes were also invited to participate during routine follow-up conversations with coordinators. Interested participants were invited to make contact with the interviewer for further information; written informed consent was obtained from all participants. Descriptions of levels and gender proportions are shown schematically in Figure 1. All participants were Caucasian and living in Ireland; ages ranged between 23 and 72 years. Participants have been provided with pseudonyms in the following analysis.

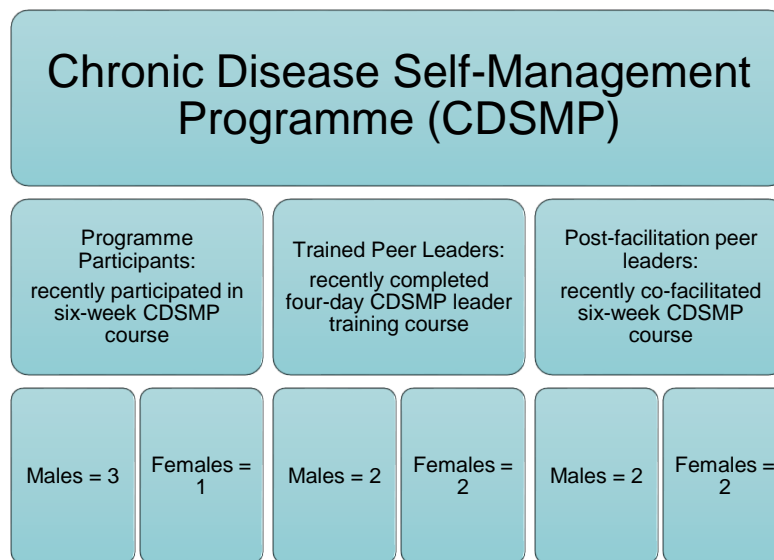


Figure 1. Participation level descriptions and gender distributions.

Design and Procedure

This study employed a qualitative based research design using individual semi-structured interviews. Interview schedules explored participants' experiences of the programme content, group processes, and the potential behavioural impact. Interviews and analysis were conducted by a researcher from a local university who at the time of data collection had no involvement with the CDSMP beyond this study. The study was approved by the relevant university ethics committee; the affiliated hospital noted it as a service evaluation as per local procedures.

Analysis

Interviews were transcribed verbatim by the interviewer and analysed using descriptive-interpretive thematic analysis guided by Elliott and Timulak¹², with procedures for enhancing trustworthiness directed by Williams and Morrow¹³ (e.g. use of direct quotes to demonstrate links between data and interpretations; checking interpretations with members of the research team). Interview data were first coded and meaning units extracted; these were then sorted and re-sorted until all units could be optimally grouped into overarching categories with associated themes. Interview data was initially coded within its particular strand i.e. individual coding for programme participants, trained peer leaders and post-facilitation peer leaders respectively.

However, after exhaustive analysis of meaning unit sets it became clear that despite the different experiences of interviewees, similar units emerged across all levels of the data-set and these could be optimally sorted into overarching categories with corresponding sub-categories.

FINDINGS

Three major categories were identified during analysis; these are depicted with corresponding themes in Figure 2 and will be interpreted with specific reference to the data.

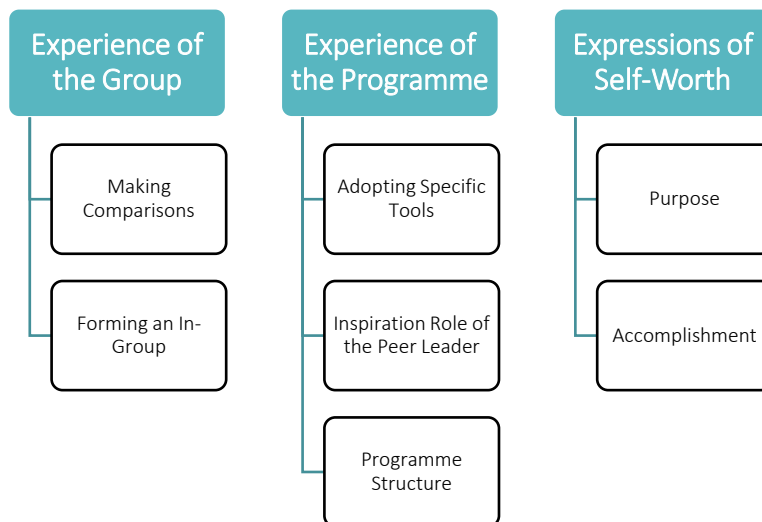


Figure 2: Categories and themes identified during analysis

Experience of the group

The data indicated that the group component of the CDSMP formed a primary element of the experiential process at both programme and leader training levels. Two themes were identified.

Making Comparisons. Across all three levels of participation, there was an expression of the comparative nature of the groups; in hearing the stories of other people in the group, participants made conscious references to their own experiences with illness. Several participants emphasised the feelings of relatedness and empathy that came from listening to fellow group members discussing health issues.

“Every one of us sort of felt the same on the way around so I knew I wasn’t alone in other words, I didn’t feel that I was different to anyone else”

Myles, Programme Participant

That people with different chronic conditions were present in the groups also offered participants new perspectives with which to view their own situation. In this sense, they compared their illness with the illnesses of others, using the ‘other illness’ as a framework for comparison.

“Sometimes you look at your own ailment as you know woe-be-tide you know things are terrible for me and then you listen to what other people have, their problems and you

know it just puts things into a different perspective”

Malachy, Programme Participant

Forming an In-Group. A second thread that emerged was participants’ view of the group members including themselves as a specific social group with which they strongly identified. The formation of such in-groups can be attributed to two central factors, the first being the common illness-related features shared by members as described above, and the second being common goal of people within the groups at both participant and peer leader trainee level.

“I didn’t feel alone, I felt I was part of something”

Myles, Programme Participant

In the context of leader training, the very clear existence of a common goal— i.e. to successfully complete the course – allowed for the breakdown of an identified barrier between ‘patient’ and ‘healthcare professional’. The in-group formation allowed for peer leader trainees to see from a different perspective the role of different healthcare professionals and provided

a sense of being 'heard'.

"If you go into a clinic or even on a one-to-one session with a counsellor or psychologist...there's kind of a wall or a barrier whereas in this case there are no barriers everyone's there just to share knowledge"

Dominic, Trained Peer Leader

Experience of the Programme

The category Experience of the Programme relates to the ways in which participants experienced the specific elements of the CDSMP, and both the positive and negative aspects that informed their level of trust in and acceptance of the course. The three themes identified were: Adopting specific tools; Inspiration role of the peer leader; and Programme structure.

Adopting Specific Tools. Several components of the CDSMP structure emerged as having particular resonance for both programme participants and trained peer leaders, who as part of training are asked to complete the various elements of the programme. The most salient element was the weekly action plan. Participants associated this element with feelings of motivation and drive, while other elements were also noted as effective self-management tools which helped participants to cope with their illness in everyday life, such as practiced breathing exercises, problem-solving and communication strategies.

"I'll do the breathing exercises or I'll listen to the tape doing me breathing and it does, it does help and it relaxes you that much, the pain is still there, but...it's dealing with it"

Myles, Programme Participant

Additionally, post-facilitation peer leaders identified the experience of witnessing their programme participants successfully adopting the same tools, and the effect that it had on them over the course of the programme.

"I think it's very motivating...to see the action plans as well like growing every week... the first week they tend to be quite small... but as the leaders' actions plans expand the group tends to keep up as well and they're kinda they're branching out, they're getting a lot braver"

Leah, Post-Facilitation Peer Leader

Inspiration Role of the Peer Leader. The purpose of the peer leader role in providing inspiration for programme participants in attaining goals emerged in the analysis of responses as as a facet of broader belief in the CDSMP. In the first instance, programme participants recognised the 'role model' status of the peer leader, as someone who experienced the same disease-related challenges as them but who represented the possibility of overcoming said challenges to achieve goals within everyday life.

"I think she was fantastic, first of all to do it and then to go every week when she felt really rotten you know and she really never said anything about feeling rotten, she just kept going"

Leanne, Programme Participant

Trained peer leaders experienced leader inspiration in two senses: firstly, in their aim to learn how to successfully fulfil the function utilising effective modelling, and the second in their response to their master-trainers, at least one of whom was also a peer. The responses suggest that peer leader trainees were initially inspired by their own master-trainers, and in turn developed the hope of imparting such inspiration to their future programme participants.

"One trainer who has a chronic illness himself just you could see that he really believed in the content and how much it had helped him, and that inspired me to go away from the training then and put some of these things into practice myself"

Zara, Trained Peer Leader

Similarly, post-facilitation peer leaders identified a desire to inspire participants

through their own experiences.

“We can show ourselves being ill like we can show that we’re in pain and stuff but the point is to show that that doesn’t stop us”

Leah, Post-Facilitation Peer Leader

The peer leader role appears from the data to play a subtle but clear role in incorporating into the CDSMP an implication around learning through modelling.

Programme Structure. The level of structure contained within the CDSMP was identified as a potential challenge. While the reasons for the highly structured approach were generally understood, there was a common thread of struggle for both participants and peer leaders in the desire to ‘go beyond’ the programme structure to further help people.

“There’s so much packed in to those two and a half hours...I found that there was little time to talk to people little time to get to know people and I found that a little bit frustrating”

Marian, Post-Facilitation Peer Leader

The structure of peer leader training is different from the CDSMP itself, made up of four full-day sessions. This intensive approach posed a challenge for interviewees, in the practical management of their symptoms for protracted periods; however, the level of accomplishment in being able to successfully adhere to this concentrated structure was also evident.

“When I came out the other end of it I was physically exhausted but that’s ok because I was tired from actually doing something constructive with my day you know which was great and it really did give me a sense of achievement”

Zara, Trained Peer Leader

Expressions of Self-worth

The final category relates to participants’ expressions of self-worth upon completion of their particular role in the CDSMP. It is likely that the previously described categories largely contributed to the development of this category, in the enhancement of feelings of self-worth across the three

groups. Positive expressions of self-worth emerged from the data as being directly attributable to the successful completion of the CDSMP, and were expressed primarily in terms of purpose and accomplishment.

Purpose. A sense of purpose was expressed in the feeling of contributing to the world, largely associated with data from trained peer leaders and post-facilitation peer leaders. These participants derived purpose from being able to help other people, using their experiences to bring positivity to themselves and others.

“A sense of purpose [...] I was just doing stuff for myself at home or trying to get through the day or whatever so now that I can look back and know that I’ve helped those people”

Leah, Post-Facilitation Peer Leader

Accomplishment. There was a particular sense of accomplishment among peer leaders at both levels, both for the role they played in helping others but also in being able to successfully complete the programme despite their illness. The identity of peer leader was associated specifically with feelings of self-worth, in providing participants with a defined role that went past their illness status.

“It just gives you a sense of self-worth, you know it [...] makes you realise you’re human you know, you’re not just a disease with a pair of legs”

Dominic, Trained Peer Leader

DISCUSSION

The aim of this research was to gain a better understanding of the personal experience of taking part in the CDSMP, through descriptive-interpretive analysis of

data from semi-structured interviews with programme participants, trained peer leaders and post-facilitation peer leaders. The primary categories which emerged during analysis were experiences of the group, experiences of the programme, and expressions of self-worth. Overall these categories indicate that the CDSMP, through facilitating positive social interactions as well as effective self-management tools, has the capacity to enhance levels of self-worth as reflected in feelings of purpose and accomplishment. These results add further weight to positive findings from quantitative studies which have shown its propensity to enhance emotional well-being and self-efficacy and reduce distress among other gains over long-term periods^{1,2,11}, and they also echo the emphasis placed by writers such as Yalom and Leszcz¹⁴ on supportive group dynamics in therapeutic groups.

Heightened self-efficacy has been recognised by CDSMP developers as being an important mechanism through which the programme impacts disease self-management.¹⁵ Lorig and Holman in turn demonstrated how each of the four self-efficacy sources identified by Bandura¹⁶ could be applied to the CDSMP: performance accomplishments as the skills mastery of successfully completing weekly action plans; vicarious experience as reflective of the modelling that occurs through peer leader teaching; verbal persuasion in terms of the group element of learning and implementing new behaviours in a social setting; and physiological states regarding the reinterpretation of symptoms that occurs through attributing alternative causes to negative symptomology.

Based on the categories and themes identified during the current analysis, it appears that performance accomplishments (mastery), vicarious experience (modelling), and verbal persuasion were the most salient programme elements that contributed to heightened self-efficacy. The role of social persuasion was arguably the most significant source of efficacy that emerged from the data, as both programme participants and trained peer leaders developed their confidence through engaging with the stories of people in their respective groups, experiencing relatedness and gaining new perspectives on their disease.

The development of a shared social identity was apparent in

participants' categorisation of themselves and other group members as one in-group with collective identification as well as strong concern for fellow group members' welfare - processes which have been widely established previously in social identity research.^{17,18, 19} The significance of this shared social identity was particularly apparent in the case of trained peer leaders who described the shedding of barriers between patients and healthcare professionals in the face of the common goal of completing training. This is in contrast to previous research which found there to be feelings of tension between peer and professional leaders, with peer leaders feeling excluded from the process.¹⁰ We found no evidence of such feelings, instead finding strong in-group formations at the leader training level. It is unclear whether the participants in Catalano et al.'s¹⁰ study undertook leader training as a mixed peer/professional group, however the current findings indicate this to be the optimal format for leader training as it allows for the development of shared understandings between peers and healthcare professionals, reducing social barriers and fostering bonds.

The present study has several potential limitations. The self-select method of sampling could be viewed as likely to appeal more so to those participants who thought positively of their experience. In anticipating this concern researchers at recruitment and interview stage emphasised openness to positive and negative feedback as well as the interviewing researcher's external affiliation with a local university rather than with the hosting organisation. However, these measures are unlikely to have entirely counteracted the impact of this limitation. Additionally, with a substantial rate of attrition previously measured for the

CDSMP²⁰, it may have been beneficial to use this qualitative platform to explore experiences among those participants/peer leaders who did not complete the full programme or training course, to better understand the reasons for drop-out. This may be a direction for future qualitative explorations of the CDSMP.

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CHALLENGING THE CURRENT APPROACH TO ADDRESSING MENTAL HEALTH DIFFICULTIES

EOIN GALAVAN AND SARAH THOMPSON



ABSTRACT

The paper explores the research evidence and critiques of contemporary mental health practice that have emerged in recent years. It examines some of the potential factors that help maintain this model as well as potential alternative approaches to service provision. It concludes by setting the potential implications of such critiques for Clinical Psychology practice.

INTERNATIONAL CONTEXT

In an open statement published ahead of World Health Day on 7 April 2017, the UN Special Rapporteur on the right to health, Dainius Pūras, said societies must reconsider dominant biomedical approaches to depression in line with the 'Agenda 2030: Sustainable Development Goals' which include "securing the right to health for all". Pūras (a Psychiatrist by training) stresses: "Treating depression and other forms of psychosocial distress with drugs, and medicalizing these conditions, has become the dominant approach. However, the use of psychotropic medications as the first line of treatment, especially for mild and moderate

cases of depression, is quite simply unsupported by the evidence. The overreliance on biomedical interventions causes more harm than good, undermines the right to health, and must be abandoned." Concurrently, a recent parliamentary debate in the UK held by the All Party Parliamentary Group for Prescribed Drug Dependence highlighted the serious and growing problem of rising mental health disability.¹ Robert Whitaker, (a scientific journalist), presented evidence that the rising rates of disability are correlated with rising prescription rates for psychiatric medication, querying whether the use of such medication may in some way be contributing to the rise of disability rates. This concern echoes a similar, much earlier, concern voiced by the World Health Organisation in their 1992 report on schizophrenia.²

CRITIQUES OF A TRADITIONAL BIOMEDICAL MODEL

Conceiving of mental health difficulties as deriving from underlying biological diseases is a model that remains dominant in many mental health systems worldwide. Alternative perspectives would include viewing mental health issues as fundamentally social and psychological problems influenced to a relatively minor degree by biological factors³. Professor Peter Kinderman (past President of the British Psychological Society & Professor of

Clinical Psychology at the University of Liverpool) in his book 'A Prescription for Psychiatry'⁴ calls for radical reform of mental health care. In this he argues, along with many others, that mental health problems are not best thought of as biologically based illnesses. He argues that there is no biological test or 'biomarker' for the 'biological illnesses' labelled as, for example, 'Major Depression' or 'Schizophrenia'. He states that years of extensive research into genetic links or brain based links have yielded little of value in helping people with mental health problems, or in substantiating the hypothesis that there is a genetic predisposition for Schizophrenia.^{5,6,7,8} Similarly, it has recently been reported that Thomas Insel, former head of the NIMH, acknowledged the failings of this biomedical research paradigm, stating that 20 Billion US Dollars failing to 'move the needle' on helping people with mental illness.⁹ Such critiques also point to the substantive evidence that trauma, for example, is a significant contributing factor to developing psychosis.¹⁰ Professor Kinderman's principal suggestion is that we drop the language of illness, in favour of simple, individualised, descriptions of people's problems. He argues that diagnostic illness categories like 'major depressive disorder' have little explanatory power, can ignore the context within which these difficulties arise, and may preclude further exploration of the potential many causal factors in the difficulties' origin.

In Ireland, a Vision for Change (the 2006 Irish National Mental Health Strategy document), promoted re-investment in mental health services, and largely retained an underpinning philosophy of mental health difficulties as biological illnesses requiring 'medical treatment' (predominately medication, thereby requiring specialist medical and nursing staffing expertise). The document makes little to no reference, however, to the contested nature of understandings of mental distress. Alternative perspectives, as cited above, would argue that viewing these difficulties in primarily biological terms can have many potential untoward consequences. These include reducing the individuals' sense of autonomy and control in their ability to do anything to address their problems, and an unintended increase in stigma.^{11,12,13} Such critiques also point to the potential beneficiaries of a model of mental health service provision that relies heavily on medication (e.g. pharmaceutical companies) and the potential danger that

those with vested interests may actively seek to influence prescribing behaviour for their own gain.

PRESCRIBING BEHAVIOUR AND THE REVIEWS OF EFFICACY

In terms of the efficacy of antidepressant medication, several studies have questioned the wisdom of the widespread prescription of antidepressants especially in the treatment of milder forms of depression. Irving Kirsh has delivered a review of this issue in his book *The Emperor's New Drugs*¹⁴, following on from his analysis of the FDA data in 2008.¹⁵ The research reviewed in this book, including the re-analysis of all data submitted to the FDA for approval published in 2008, (both published and unpublished studies), indicated that, according to Kirsh, antidepressants perform no better than placebo, except for the most severely depressed.

A recent report on illness benefit in the UK¹⁶ indicated that being on antidepressant medication correlated with a reduced likelihood of returning to work, a greater likelihood of remaining depressed over the long term, and a greater likelihood of relapse, than not being on antidepressant medication. This correlation could reflect the possibility that those prescribed medication were more severely depressed in the first place, however, it could also echo concerns about the effectiveness and impact of long-term use of such medication. Robert Whitaker has voiced such concerns, (in particular in relation to 'anti-psychotic' medications) in his book *Anatomy of an Epidemic*¹⁷, and more recently at a UK parliamentary debate earlier this year.¹

The evidence around prescribing, however, would indicate that the prescription of antidepressants continues nevertheless to increase: recent data published in the Irish Examiner suggests a range of 4.5-10% of the Irish population is currently taking psychoactive drugs for anxiety and depression.¹⁸ Whitaker's review cited above¹⁹ notes this trend in many countries including the UK and US.

EVIDENCE ON ANTI-DEPRESSANTS: PLACEBO, HELPFULNESS AND CONCERNS ABOUT SIDE EFFECTS

In relation to the evidence around psychotropic medication, reviews point to two areas of importance, those of the 'placebo effect' and measuring a 'clinically significant improvement'. The placebo effect has been well documented as the powerful psychological impact of taking a medication prescribed by an 'expert' other. Given that this effect commonly results in an improvement in the individual's presentation, to demonstrate a positive biochemical effect of the medication, the drug needs to demonstrate that it results in a 'clinically significant improvement' beyond that achieved by the placebo effect.

The evidence for the effectiveness of antidepressants indicates that, particularly in the most severely depressed group, anti-depressant drugs seem to offer more than placebo, although even in this group the level of difference is clinically relatively small.¹⁵ The NICE guidelines suggest clinical significance equates to a 3-point difference on the Hamilton Depression Rating Scale (HAM-D), (which is relatively small on a scale with 29 items, 6 of which relate to sleep alone). More recent research failed to find a benefit of anti-depressants above placebo when slightly more stringent criteria for clinical significance were used.²⁰ A recent systematic review²¹ published in the BMC Psychiatry suggests "SSRIs might have statistically significant effects on depressive symptoms, but all trials were at high risk of bias and the clinical significance seems questionable. SSRIs significantly increase the risk of both serious and non-serious adverse events. The potential small beneficial effects seem to be outweighed by harmful effects." In studies which concluded that antidepressants are more beneficial than placebo²² the effect sizes reported are small

(0.34) and the clinical effects, as opposed to statistical effects (2.82 on the HAM-D, with the Confidence Interval ranging from 2.21 to 3.44), are questionable when either the NICE guidelines levels for clinical significance (3 points on the HAM-D) or the slightly more stringent clinical significance levels noted above (7 points) are taken into account. Other studies conclude that there is evidence of effectiveness of anti-depressants above placebo in the severely depressed group, however still conclude that other less risky interventions should be utilised first given the small effect sizes, and acknowledge the effects of antidepressants are limited.²³

In addition, several studies have pointed to the potential risks of the use of such medication. An increased risk of suicide has been noted with black box warnings now appearing on certain anti-depressants in the US.²⁴ Sexual dysfunction is commonplace with as many as 50-80% of people taking SSRIs experiencing sexual dysfunction.^{25,26} Discontinuation syndromes are increasingly recognised with 30-50% reporting significant problems associated with withdrawal, including anxiety and agitation. This has led some to argue that SSRIs need to be added to the list of drugs that should be warned about as having withdrawal effects²⁷. A recent study at Yale University discovered there is also an increased risk of people developing bipolar disorder, when taking anti-depressant medication that appears to be precipitated by the use of the medication. Researchers found that the number of treated cases needed to harm (NNH) is 23. In other words, for every 23 people treated with antidepressants approximately one person on average will develop bipolar disorder who would not have otherwise developed this condition.²⁸

The widespread prescription of antidepressant medication needs also to be viewed in the context of the existence of other evidence based approaches which have demonstrated comparable effectiveness; such as exercise^{29,30} and psychological therapy.³¹ Access to such alternatives may be impaired, however, by a range of factors including: underinvestment in the provision of alternative interventions, the gatekeeping role to such interventions being predominately held by those with medical rather than psychosocial training (e.g. GPs), and a possible perception that prescribing antidepressants is the safest course of action with any presentation of depressive symptoms. The absence of alternative approaches may also render more likely the use of more invasive interventions, such as ECT, when successive medications have failed to be of benefit.

It should be noted that in their review of treatments of depression the National Institute for Clinical Excellence continues to recommend the prescription of particular antidepressants (e.g. SSRIs) for depression. However, the latest update states that for mild-to-moderate levels of depression such medication should only be prescribed if (a) the individual refuses psychosocial interventions (b) has tried psychosocial interventions and they have proved ineffective or (c) the prescription of SSRIs have proved beneficial for this person in the treatment of their depressive symptoms in the past.

ALTERNATIVE MODELS AND APPROACHES AND THEIR IMPLICATIONS

The prescription of psychotropic medication could be considered in the frame advocated by Professor Joanna Moncrieff in her book *The Myth of the Chemical Cure*³². Professor Moncrieff outlines a 'drug model' approach to using medications as opposed to a 'disease model' approach. In the drug model, drugs are used on the basis of the effects they actually have, which may or may not be helpful to a person at a particular time, rather than as addressing an underlying disease state or 'chemical imbalance', a theory which Moncrieff, a Consultant Psychiatrist, asserts has limited scientific evidence. This is a similar idea to the way in which paracetamol works; we take paracetamol to help with the symptoms of a headache, we do not assert that an

imbalance in acetaminophen (the active ingredient in paracetamol) caused our headache, nor do we assume that because the headache resolves after taking the medication that the reason for the headache has been discovered. A drug model approach allows for the short term, ethically informed, prescription of drugs without requiring a belief in an underlying disease process. Given the documented harmful side effects, for some, of taking certain psychotropic medications, Moncrieff advocates that these risks and side effects are carefully weighed up when prescribing and should not be the sole focus or the frontline of intervention.

Similarly, the model of care proposed by Kinderman³ would involve significant change in current practice moving from a medical care based or illness model to a psychosocial care based or psychological model. Such a shift would necessitate changes in a range of domains including: staffing, use of capital resources, the philosophical underpinning of the work, health policy and even legislation.

Staffing: Such a model would embrace a diversity of disciplines including highly trained social workers, psychologists, social care workers, occupational therapists, counsellors, psychotherapists, family therapists, social pedagogues, experts by experience, peer support workers and other community supports. Nurses and psychiatrists would continue to add their expertise on a consultative basis but not as the dominant disciplines (either in number or authority) in service provision. Decision-making, therefore, necessarily would be through agreement - in collaboration with service users and their supporters - amongst leads of disciplines rather than by a single 'clinical lead'.

Capital Resources: This would entail a move from spending predominately on centralised inpatient units to a multiplicity of sources of community support including: crisis centres, crisis houses, drop in centres, therapeutic communities and other non-medical models of interventions for more severe experiences (e.g. psychosis). Models of such centres and approaches already exist internationally and to a limited degree in Ireland e.g. the crisis houses in the UK, the Finnish Open Dialogue model (West Cork), the Parachute program in New York, the Leeds Survivor Led Crisis Service or Recovery Colleges (UK, Mayo and Roscommon).

Philosophical Underpinning: This would involve moving to individualised, formulation-based assessments of people's needs rather than a diagnostic based assessments.^{33,34} This would entail a shift towards acknowledging the central role that social circumstances, poverty, inequality, educational opportunity, family problems, relationships, stress, loss, our lived experience and trauma all play in our mental health. It is also recognises the key element that the individual's own strengths, and that of their network and community, plays in advancing their recovery goals. In this way professional expertise is de-emphasised in favour of creative, collaborative work with the service user and those around them.

Health Policy and Legislation: Under such a model, the next "Vision for Change" would embrace the values highlighted above and seek to develop mental health services wherein the challenging and powerful role of relational and emotional work in providing high quality mental health care is prized, and staff are trained and supported to do so. Similarly, ongoing revisions of the Mental Health Act would increasingly seek to empower the service user and their supporters in managing times of crisis. Such revisions would de-emphasise the role of specific disciplines, (e.g. the approved consultant psychiatrist), towards a partnership model where the senior health professional with whom the service user has the closest relationship has greatest say in their inpatient care. Again, this may involve a reformulation of roles and further training.

CONCLUSION

Broader social and economic forces may have influenced the

path taken by Clinical Psychology in recent decades. The wish to demonstrate the evidence base for psychological interventions has led the widespread adoption within large research trials of the "diagnosis – intervention" model of assessing effectiveness. This may have brought significant gains in promoting the benefit psychological intervention can bring to individuals in distress. It may, however, have come at the price of obscuring social, political, developmental and interpersonal contextual factors that were crucial both in the aetiology and resolution of many of these difficulties. Increasingly, the potential harm of adopting a "disease model" of understanding mental distress is being highlighted across disciplines, including within psychiatry itself by individuals such as Sami Timimi and Pat Bracken (cf: critical psychiatry network). Increasingly, international psychology bodies are critiquing and often rejecting a diagnosis-led model of service provision. The British Psychological Society have published a range of documents influenced by such thinking (cf: recent BPS publications on Psychosis³⁵, Bi-Polar Disorder³⁶ and a critique of the DSM type diagnostic system³⁷).

Professor Kinderman's work in this regard constitutes an evidenced based manifesto to radically transform mental health care.⁴

To advance many of the values espoused in such an approach, Clinical Psychologists in Ireland would need to consider a range of actions including:

- Advocating that the professional organisations (e.g. PSI) actively petition the government to review mental health policy and legislation in

light of the evidence outlined above, and in light of calls for a 'rights-based' reshaping of mental health services.³⁸

- Within Clinical Psychology itself that the profession should consider promoting the Psychological Model of Mental Disorder³ and recovery oriented approaches, as viable alternatives to the current prevailing illness model.
- That the profession advocates for leadership and decision-making process within mental health services focused on service user preferences and specific expertise in specific domains (rather than a singular clinical lead model).
- That the profession seeks to fully embrace the service user movement and principles of co-authoring and collaboration in a meaningful way.

Given their in-depth and extended training, Clinical Psychologists can play a useful role in promoting this organisational change and are well equipped, along with others, to inform how such services could be structured and delivered, ultimately to the benefit of all.

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SERVICE USERS' EXPERIENCE OF WARD BASED THERAPEUTIC PROGRAMMES

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OVERVIEW

Over the past 50 years there has been a gradual shift in the view that mental health inpatient units are an environment in which little therapeutic intervention can be offered.¹ A Vision for Change², which sets out a comprehensive policy framework for our mental health services, recommended an increase in multidisciplinary group therapy programmes in inpatient settings. Consequently, inpatient units have gradually endeavoured to offer multidisciplinary group therapy programmes with the aims of improving interpersonal skills, decreasing symptoms and facilitating discharge². In line with AVFC recommendations, acute mental health units across HSE South (Community Healthcare Organisation Area 4; CHO area 4) have introduced ward based therapy programmes. In 2015, the Mental Health Commission published the Judgement Support Framework³ to ensure compliance with regulatory requirements and to improve the quality of services provided to service users in mental health inpatient units. Consequently, the provision of these services has been regularly audited and local Mental Health Services within CHO Area 4 are committed to researching the ward based therapeutic programmes more rigorously in order to shape

and improve future delivery. Furthermore, one of the most progressive recommendations in AVFC is that service users should be involved in every aspect of mental health service development and delivery. This report summarises the findings of service user's perspectives of ward based therapeutic programmes in three adult mental health inpatient units in HSE South.

BACKGROUND

Service users

AVFC recommends user (and carer) involvement at every level of the mental health service delivery and development². There are a number of reasons why mental health service user involvement is a worthwhile activity with a range of practical and ethical benefits. For example, user involvement may be therapeutic in itself, and may encourage social inclusion⁴. Consequently, in recent years there has been increasing attention paid to service user feedback in Ireland as it influences the shape and delivery of mental health services. In Ireland and the UK there has been much research conducted on the experiences of mental health service users despite mental health service user involvement being a relatively new phenomenon in the Republic of Ireland⁵⁻⁸. However, there is a limited amount of research targeting service users' experiences of inpatient groups.

Inpatient group therapies

A meta-analysis of 70 studies of inpatient group therapies conducted between 1980 and 2004 reported that inpatient group therapy has a significant positive effect on patient outcomes and recovery.⁹ However, running and evaluating group therapeutic programmes in inpatient settings is notoriously difficult as individuals have acute presentations, are often heavily medicated and are often receiving a standard package of care. Consequently, the ecological validity of applying evidence based treatments in an inpatient setting is questionable due the complexities of outcomes as already stated. At the same time groups can afford an important socialising impact, make a significant contribution to the therapeutic environment of the ward, and can provide structure, purpose and therapeutic features to a hospital stay.^{7, 10, 11} O'Donovan et al.¹² identified a number of benefits of an inpatient group programme, which were consistent with Yalom et al.'s¹³ therapeutic factors, such as universality, interpersonal learning and the development of socialization techniques. More recently, findings from research carried out by Dempsey et al.¹⁴ in a local regional inpatient unit were consistent with these themes. Indeed the therapeutic elements reported could also be conceptualised as pre-therapy competencies¹⁵. Pre-therapy can improve inpatient service users' capacity for being in contact with others, and communicating about themselves and their world, which can contribute to their ability to participate in, and profit from one to one psychological therapies.

Stanley et al.¹⁶ also identified benefits of attending inpatient groups. They reported that service users felt more involved in their treatment, perceived the ward as more therapeutic and service users' relationships with others in the unit improved as a result of attending groups. Furthermore, Shattell et al.¹⁷ reported that service users felt that psychoeducational and reference material would support recovery. However, unhelpful aspects of inpatient groups have also been highlighted such as other service users' disruptive behaviour in groups, and irrelevant content of groups.

Research Rationale

The acute mental health units across CHO Area 4 have a long history of providing multidisciplinary care. In line with AVFC recommendations, the ward based therapy programme in its current form was introduced to one of the units included in this study in 2009. The programmes involve a wide range of stand-alone intervention groups, with significant multidisciplinary input from Clinical Psychology, nurse therapy, occupational therapy, and art therapy. A key objective of the revised programme was to provide a more varied programme of interventions to meet the needs of all service users, with both acute and chronic/enduring mental health difficulties. Parallel programmes have since been introduced in two more mental health inpatient units in the local area.

Objectives

Specifically, the study aimed to answer the following research question: What are the service users' experiences of the therapeutic groups in terms of clinical and social aspects, and areas where the programme could be improved. The capacity for such groups to promote key pre-therapy competencies, such as engagement, reflection, working in a relationship with others is important in contextualising the project.

METHODOLOGY

A qualitative methodology was used in this project which was undertaken in three acute adult mental health inpatient units across CHO Area 4. This involved collecting data through the use of focus groups and subsequent thematic analysis.

Table 1. Inpatient group programmes

Discipline	Unit 1	Unit 2	Unit 3	
Nurse Therapy	<ul style="list-style-type: none"> ○ Community Meeting 	<ul style="list-style-type: none"> ○ Problem Solving ○ Anxiety Management ○ Being an Inpatient ○ Challenging Negative Thinking ○ Communication Skills ○ Connecting Emotions ○ Coping with Distress ○ Healing with Compassion ○ Improving Sleep 	<ul style="list-style-type: none"> ○ Mindfulness ○ Relaxation ○ Women's Group ○ Men's Group ○ Community Meeting ○ News & Views ○ Out & About ○ Games Group ○ Understanding my Care Plan 	<ul style="list-style-type: none"> ○ News & Views ○ Community Meeting ○ Walking Group ○ Mindfulness Approaches ○ Baking Group
Clinical Psychology	<ul style="list-style-type: none"> ○ Letting go of Unhelpful Thoughts ○ Managing Upsets and Distress using 5 Senses ○ Mindfulness ○ Relaxation Skills ○ Sleep Management ○ The Power of Distraction 	<ul style="list-style-type: none"> ○ Problem Solving ○ Anxiety Management ○ Being an Inpatient ○ Challenging Negative Thinking ○ Communication Skills 	<ul style="list-style-type: none"> ○ Connecting with Emotions ○ Coping with Distress ○ Healing with Compassion ○ Improving Sleep ○ Mindfulness 	<ul style="list-style-type: none"> ○ Anxiety Management ○ Communicating about your Mental Health
Occupational Therapy	<ul style="list-style-type: none"> ○ Goal setting group ○ Healthy Bites ○ Mindfulness Movement ○ Gardening 	<ul style="list-style-type: none"> ○ Social Group ○ Working Towards Discharge ○ Bingo ○ Community Meeting 	<ul style="list-style-type: none"> ○ Craft Group ○ Exercise ○ Cookery & Baking ○ Out & About 	
Art Therapy	<ul style="list-style-type: none"> ○ Art Group 	<ul style="list-style-type: none"> ○ Art Group 		<ul style="list-style-type: none"> ○ Hearing Voices Group ○ Art Group

The three inpatient units involved in the research together provide care and treatment for approximately 110 people.

49 ward based therapeutic groups were included in the evaluation. At the time of the study, all therapeutic groups were open and scheduled Monday to Friday on a daily, bi-weekly and weekly basis. Table 1 outlines the types of therapeutic programmes run at the three units which were facilitated by nurse therapy, Clinical Psychology, occupational therapy and art therapy at the time the study was undertaken.

Sample

The sample consisted of 17 service users (age range: 20-64 years. See Table 2) who were at the time inpatients. The inclusion criteria outlined that participants should be over

18 years of age, and had the ability to give informed consent. Suitable participants for the focus groups were identified by the clinicians responsible for co-facilitating the respective therapeutic groups. This was based on their perceived wellness and ability to contribute. The selected participants were then invited to participate in the focus groups. No distinction was made between which groups the participants attended as the overall aim of the programme was the same.

Table 2. Composition of focus groups

	n	Male	Female	Age Range
Group 1	5	5	0	20-58
Group 2	6	2	4	33-57
Group 3	6	4	2	37-64
Total (N, gender, age range)	17	11	6	20-64

Ethics

The study was granted full ethical approval from the local Teaching Hospitals' Ethical Committee. Those who volunteered to take part in the study were informed that their participation was voluntary and they were free to withdraw from the study at any time, would not affect their treatment in any way.

DATA COLLECTION AND ANALYSIS

Data Collection

Data was collected over a period of 4 weeks across three sites in February 2017. One focus group was conducted per inpatient unit. Due to the semi-structured nature of the interviews any new topics raised by participants were explored by the researcher. Moreover, participants were encouraged to be critical as well as positive in their feedback. Focus group facilitators (i.e. the principal researcher plus one Clinical Psychologist) had no involvement in the delivery of the therapeutic programmes at individual sites. All interviews lasted between 45 and 60 mins.

Qualitative Data Analysis

Thematic analysis was used to identify, interpret and report organising or overarching themes. The steps taken in conducting thematic analysis follow those recommended by Braun et al.¹⁸

The process involved six main stages: verbatim transcription, detailed reading of the data, identification of data sets, identification of initial themes from the data sets and coding, refinement of themes, and clustering themes into coherent groupings (samples of coding available and full transcripts).

The themes and sub-themes identified are summarised in Table 3 below.

THE FINDINGS

Four dominant themes emerged from the data analysis. These themes highlighted the value service users placed on the programmes, the beneficial aspects, as well as emphasizing areas for improvement:

- Self-care & Recovery
- Safety
- Emotional Connection
- Suggestions for Improvement

Theme 1: Self-care & Recovery

All participants reported that the therapeutic group programmes were an important aspect of their care and impacted on their recovery. Service users noted that the groups gave them the opportunity to have a better understanding of themselves, helped them to not focus too much on their personal difficulties and improved their psychological well-being.

"They get you to think about your health.....they get you out of your own headspace and give your mind a break."

Participant 13

"I find that they're good too for recovery, because they're giving you ways of dealing with your stress and how to deal with your emotions"

Participant 6

Many participants also described the value of daily structure and routine which the group programme offers, and were generally positive about the encouragement the ward staff provide to attend groups when they cannot self-motivate.

"The groups give a sense of continuation and a sense of achievement at the end of the day."

Participant 9

Participant 17

"The groups help me to integrate with people a little bit better. It just brings me out of my shell."

Participant 15

Theme 2: Safety

Participants described the sensitivity and respect they were offered by the group programme facilitators which contributed positively to engagement.

"They make you feel a lot more comfortable for you, more relaxed. Safe if you like."

Participant 9

Many participants also reported that attending the groups allowed them to realise that other people had similar problems which helped them feel less daunted by the experience.

"Everyone is in the same boat that you're in and you feel that you're in a sheltered environment, that you're all in the same boat...We're all one little close knit community."

Participant 5

"It helps you to feel normal like. People have different ways of looking at things and it feels nice".

Participant 1

Theme 3: Emotional Connection

The opportunity to relate to others was highlighted by the majority of the service users as the most important aspect of the therapeutic programmes. They valued the experience of empathising and connecting with others, which for some improved confidence and for others reduced isolation.

"You're listening to hardships, you're listening to reality and you can connect with that and you hear someone else that you can also connect withIt's a huge understanding to feel that connection with others."

Participant 14

The groups bring you closer to people, have given me more confidence I suppose ... We share the same kind of ongoing things maybe as well.

Theme 4: Suggestions for Improvement

Participants noted that some of the groups can be repetitive and unvaried, particularly for those longer stay inpatients, and would like new material introduced.

"At the moment it's one size fits all. Some people just in the door might love it and people here longer could completely disengage with it."

Participant 8

Furthermore, some service users expressed a desire for more psychoeducation regarding their specific diagnosis and mental health difficulties to aid recovery. Additionally, they suggested that the groups should focus more on specific illnesses, such as bipolar disorder or depression. Focus groups participants also expressed a strong desire for weekend activities and for additional groups that included music and dance.

"I think somethings that are lighthearted and a little bit fun would be really great."

Participant 3

Table 3: Themes and subthemes identified in transcripts

Themes	Subthemes
Self-care & Recovery	<ul style="list-style-type: none"> ○ Structure ○ Motivation ○ Skills and Learning ○ Sense of meaning/achievement
Safety	<ul style="list-style-type: none"> ○ Equality & acceptance ○ Normalisation ○ Comfort
Emotional Connection	<ul style="list-style-type: none"> ○ Shared understanding ○ Reduced isolation ○ Sense of belonging ○ More confidence from interaction
Suggestions for Improvement	<ul style="list-style-type: none"> ○ More variation of materials/groups targeted at specific problems ○ Schedule activities at weekend ○ Inclusion of 'light-hearted' activities ○ Reminders by staff of the benefits of specific groups

DISCUSSION

The qualitative analysis of service users' perspectives revealed high levels of user satisfaction. Service users reported many benefits and viewed the therapeutic programmes as an important aspect of their recovery. Structure and routine was viewed as a practical and primary feature of the programmes, which strongly contributed to service users' emotional health by giving a sense of structure, a sense of achievement, and meaning to their days on the ward. There is an abundance of recovery literature relating to the positive effects of daily structure and routine in coping with many mental health difficulties. For the most part such research reports the crucial components of routine and daily meaning to building healthy life structures¹⁹, which for inpatient populations have generally broken down.

In addition, one of the key benefits reported by participants was being provided with the opportunity to relate to and connect with others, which fostered a sense of belonging, improved social interaction, increased communication, and thus, reduced isolation. They also described a process of normalisation through shared experiences, which provided a sense of safety and comfort. These findings are similar to research conducted on group therapeutic programmes in adult mental health inpatient units.¹²⁻¹⁴ Moreover, these

reported benefits reflect Yalom et al.'s¹³ therapeutic factors of participating in a group format, specifically, universality, interpersonal learning, cohesiveness and the development of socialisation techniques.²⁰ These generic benefits appear to be prevalent irrespective of the service users' preferred type of group or service users' individual difficulties. The results support the notion that ward groups improve morale.²¹ This provides positive affirmation and support for the current offerings of therapeutic programmes in the participating units. Moreover, no specific group format was described overall as the most or least beneficial, highlighting the range of individual preferences and the value of a variety of groups. A holistic approach incorporating activity based groups, discussion based groups, and groups focussing on coping strategies, has been reported in the literature as necessary to promote recovery and wellbeing.²² These reported therapeutic benefits are important because (1) they are core aspects of psychological wellbeing and positive experience; (2) they promote pre-therapy competencies of sociality, and a return to reality; and (3) in light of the difficulties of researching and running evidence based therapies within an inpatient setting, the process of taking part in groups may well be one of the primary therapeutic benefits at this level of care.

Very few aspects of the programmes were seen as unhelpful by the participants. Some participants highlighted that the content of some groups was repetitive and undeveloped and considered it a potential contributing factor to disengagement and reduced attendance. They described this as a drawback for (1) those who had more insight into their difficulties, and (2) for those who were on longer hospital stays. Additionally,

they suggested developing programmes depending on ability levels and length of stay. The inpatient units included in the study cover a large catchment area, with rural, sub-urban and urban regions. Therefore running group programmes that take into account a variety of backgrounds, educational levels, and length of stay can be particularly difficult. However, it may be possible to address this by recommending particular groups to participants depending on levels of educational ability and current functioning¹². Alternatively, a modular structure could be implemented enabling service users' to tailor their own therapeutic programme.

Other participants highlighted the need for specific groups that focus on particular conditions and more psychoeducation provided regarding different mental health difficulties. This reflects findings by Shattell and colleagues¹⁷, who reported that service users felt that education, information and reference material would support recovery. The provision of group activities at weekends was also regarded as an area for improvement as some participants felt that a reduced structure and engagement with others at weekends interrupted personal progress achieved during the week. Furthermore, helpful suggestions regarding the inclusion of music based activities, animal therapy, and more 'light hearted' offerings were also expressed and considered important for overall mental health and wellbeing. It was acknowledged that the services already attempt to deliver a varied range of activities targeted at different interests and ability levels. Related to this point, participants also noted that generally their ability to engage in different groups on daily basis depended on their mental states.

There are limitations to the study which need to be considered when interpreting the results. This was a small scale study with a small sample size therefore themes should be regarded as indicative rather than representative, particularly as participants of alternative group therapy programmes might privilege different issues. It was undertaken in only three acute inpatient units in HSE South and therefore findings are contextually bound. As already mentioned, user satisfaction was high and most responses were positive in nature. This could be related to the fact that focus groups were conducted while they were inpatients and it is possible that patients were reluctant to make negative

comments because of possible repercussions. Furthermore it is also recognised that participants may have experienced difficulty expressing their opinions in a focus group setting if they had previously struggled with group membership.

From this, a number of recommendations arise:

- Suggestions and critical reviews by the service users' should be reflected on and considered for future programme development in order for service user involvement to be meaningful and more than simply a political mandate. For example, implementing a modular structure enabling service users' to tailor their own therapeutic programme.
- At a time when resources are limited, recommended further research should explore whether it is largely the process of taking part in groups that benefits inpatients, and which core principles make a therapeutic programme valuable
- Informed by the main themes identified in this evaluation, services and the reported benefits could implement a protocol aimed at improving membership to group programmes grounded in the lived-experience of those who actually use the service
- Periodical audits should continue to be conducted to ensure comprehensive evaluations given the acuity of presentations in inpatient wards on any given week and the possibility of identifying further therapeutic gains and areas for improvement.

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BEING A TRAINEE CLINICAL PSYCHOLOGIST: REFLECTIONS ONE YEAR ON

EMMA HENNESSY



SUMMARY

Reflective practice is an integral aspect of Clinical Psychology and is referenced by both the Psychological Society of Ireland and the British Psychological Society as a necessary element of training programmes for accreditation. This article represents a reflection on the beginning of clinical training and settling into the role of a trainee. It follows three main themes: the establishment of new working relationships; the process of learning how to sit with urges to always 'do' something with clients; the urge to 'fix' their difficulties for them; and therapeutic endings. The merits of reflective practice are explored in the context of personal and professional development.

INTRODUCTION

Reflective practice is becoming an increasingly valued domain in Clinical Psychology – particularly in the area of clinical training¹ and is referenced by both the Psychological Society of Ireland (PSI) and the British Psychological Society

(BPS) as a necessary element of training programmes for accreditation.²⁻³ Bolton⁴ describes how reflective practice can enable professionals to learn from experience about: themselves; their work; the way they relate to home and work, significant others and the wider society and culture. Moreover, the PSI states that courses 'should ensure that trainees are cognisant of the importance of self-awareness and the need to appraise and reflect on their own practice'.^{2(p4)} There are many benefits to be reaped from practicing in this way.

Alarcon and Lyons⁵ postulate that engaging in reflective practice leads to an increase in job satisfaction and a decrease in work related stress for the practitioner. They also highlight that the practitioner can experience greater empathy between them and their clients as well as a greater unity and wholeness of experience in their work. Schon⁶ suggests that it helps professionals to make complex decisions in challenging situations without access to all existing information through a two-part process: reflection-in-action (during the event) and reflection-on-action (after the event). He also states that it enables us to wonder at our own work, our world and indeed ourselves, because 'problems do not present themselves to the practitioner as givens...he must make sense of an uncertain situation that initially makes no sense'.^{6(p40)}

This article explores my personal and professional development as a trainee Clinical Psychologist thus far. It focuses on the process of settling into the role of a trainee in my first placement (adult mental health), and the importance of clinical supervision in facilitating this. More specifically it will cover the establishment of new professional (supervisory) and personal development relationships, the process of learning how to sit with my urge to always 'do' something with clients and my desire to 'fix' their difficulties for them. It will also explore my first set of endings as a trainee, both with my clients and my supervisor.

A new set of relationships

As I took the next step in my journey to becoming a Clinical Psychologist I formed two new relationships, which became of great importance to both my professional and personal development. I began my first placement and so a new supervisory relationship. This brought with it a range of feelings. In honesty, although excited and eager to get started, I felt slightly overwhelmed and uncertain as to whether I possessed the competence to provide my clients with a service comparable to what they would receive if seen by a more senior clinician. Jenny Webb described such feelings accurately when discussing trainee's experience of beginning new placements: "You may be assailed by a combination of heroic good intentions and feelings of ignorance and incompetence".^{7(p4)} I also wondered whether I was as fit for the job as my fellow trainees and felt a desire to impress my supervisor with my up-to-date knowledge so that she would think of me as a 'good trainee'. I identified with what I now know to be 'imposter syndrome'.

I realized my feelings were not in isolation when I read Clance and Imes⁸ paper entitled 'the imposter phenomenon in high achieving women: dynamics and therapeutic intervention'. I immediately recognised some of myself in the article, particularly my ability to dismiss high grades and achievements as lucky breaks. As I explored this further in supervision I became comforted in the knowledge that my enthusiasm and dedication for helping my clients, along with two hours of formal supervision a week, as well as class discussions, meant that my clients were actually receiving

plenteous expertise and input. In keeping with this and grounding myself in knowing that I will have at least something to offer my clients, a line I read by Nancy McWilliams^{9(p47)} stood out to me; 'the uniqueness of every person makes it impossible ever to be fully prepared for the next client'.

At this time, I also began my own personal development journey with a psychotherapist with the aim of gaining a greater understanding of myself and also to experience therapeutic processes from the client's seat. Some research findings also suggest that engaging in personal therapy can enhance reflective practice capacity for psychologists.¹⁰ My first session showed me how intimidating it is to sit across from a complete stranger with the expectation of sharing my inner most feelings with her. I felt the need to tell her on meeting that I was a trainee Clinical Psychologist, to which she responded with little reaction. In the next session we spoke about this. Ashamedly I admitted that I had offered this information to highlight that I didn't need to be there, but that I was present as a matter of exploration. Together we discussed the sense of stigma and shame I was alluding to at coming to therapy. It made me sit back and realize what courage my clients were already coming to me with in that they were brave enough to seek and admit they needed help with their distress.

I began to wonder if my feelings in starting with both a new supervisor and a therapist could be comparable to those of my new clients – overwhelmed, hesitant, unskilled and cautious of beginning a new relationship despite how attractively it was

presented. This in itself was interesting to reflect on and I believe kept me mindful in my initial sessions with clients as to just how daunting this must be. I endeavored to keep a strong focus on building a therapeutic alliance with them so as to create a safe space from which to explore themselves and also as the therapeutic alliance is noted to be a significant factor in facilitating therapeutic change.¹¹

As my capacity to share my thoughts, feelings and emotions grew in supervision, I began to notice the impact of this on my client work and how my capacity to offer the same trusting space for my clients grew too. Being allowed to set the agenda for the meeting anchored me in the supervisory relationship. It gave me a sense of empowerment and validation in that I knew the meeting was focused on my needs. This was something I tried to do with my clients. I hoped that giving them this opportunity would instill the same sense of confidence building in learning to get their needs met. I had one particular client who was observed to have difficulty each week in setting the agenda and thinking about what it was she wanted to discuss. When speaking in supervision it was noted that the clients upbringing was marked with disruptions to key attachment relationships such that she may have internalised a sense that her needs were not important or worthy of being met, including in therapy. Gray¹² talks about the importance of acknowledging this potential in clients with a history of difficult early childhood experiences. This experience showed me the importance of recognizing that we as human beings function on many different levels other than verbal, and so sometimes what is not said in-session but may be conveyed through behaviours is important to consider when working with clients.

The need to 'do'

Although I see myself as a somewhat natural reflector, often in supervision I found myself eager just to stick to the facts of 'what had gone on in my week'. Reflecting now I feel this was most likely as I wanted to prove myself as a capable trainee and was conscious that I wanted my supervisor to know 'just how much I had done this week'. I was lucky to have caught myself doing this as it started to spill into my

client work. In an effort to ensure that I completed by-the-book CBT with one of my clients, I found myself getting lost in the pragmatics of it, focusing on what we needed to get done in the session, what I had prepared for the session and so not being fully present for what she was bringing as in a way, it didn't fit into my schedule. I recall, when asked about the week just gone, referring in passing to the anniversary of a major loss. While not on the "agenda" for that session, it was only as a consequence of us given that issue real time and importance that we were able to discuss something of real importance to that client. Following the session, I brought this to supervision and reflected on how I had almost let my need to 'tick the CBT box' surpass my client's needs and which could have led to a rupture in our therapeutic relationship as well as him feeling invalidated. Moreover, in research findings it is the 'heroic' client's efforts and the personal attributes a therapist brings to the therapeutic relationship that effect change in therapeutic outcome, rather than any particular technique or therapeutic orientation preferred by the therapist.¹³

Another example of this came with a client where following the assessment process; I presented my detailed hypothesis of the nature of her difficulties discussed and their origin. The client didn't particularly agree, however, with the formulation and we agreed to rework it together. We then contracted for therapy, but quite soon after, she disengaged. On reflection, I believe that my rush to present her with a complete and intelligent formulation meant that I missed the mark. Levy stated

that this can be 'a stance many therapists find difficult [a more cautious and less interpretive mode of formulation] because of their own neurotic needs to be brilliant and special in both their patients' and their own eyes'.^{14(p24)} Perhaps more time spent reflecting on this at the time would have resulted in a different outcome for the client. Page, Stritzke, and McLean's¹⁵ paper found that participants (psychologists) valued the role of reflection as part of the process of developing a formulation, especially when working with cases that they identified as challenging or perceived they were 'stuck' with. Supervision helped me see that assessment and formulation are continuing processes throughout therapy and meeting the client where they are at is by far the most important outcome. It helped me to become OK in just being with a client and not always focusing on the doing.

The need to 'fix'

Mason¹⁶ described a position of 'safe uncertainty', meaning that a person feels able to tolerate not knowing exactly what to do with a client and engage in the creativity that is provided by this position. He suggests it comes with feeling contained by a positive supervisory relationship. Pica¹⁷ further elaborates on this concept and suggests that a certain amount of uncertainty is necessary in clinical training programmes as it forces the trainee to enhance their critical thinking skills through having to focus on how and why a client is saying something and not just what is said. For me, once the supervisory relationship became more established I then began to feel more at ease with thinking out loud and sharing my uncertainty with my supervisor, as opposed to needing to appear confident and competent at all times. Being given a 'wondering' stance in supervision, whereby my supervisor did not immediately provide me with the answers I was looking for, allowed me to do the same with my clients.

However, earlier in my placement I struggled more with uncertainty and felt a need to 'fix' my clients difficulties and provide them with the solutions to do so. This led to discussions in supervision about the meaning of progress and change to both client and therapist. Subsequently I explored with clients what change meant to them, whether it was something aspired towards or something frightening,

leaving behind the safety of their current position.

In my own personal development work, I spoke about my feelings of working with such clients and whether it was OK to feel frustrated. My therapist asked me two things - what change meant to me, and how I would respond if I were asked to try something new, yet difficult. This was interesting for me to reflect on in that change is something I certainly find difficult and have struggled with in the past. What is more, I realized that perhaps I would be quite compliant if asked to do something, wanting to please the other person. In thinking about this it made sense to me why I was frustrated with such clients - I was imposing my own beliefs on them. It highlighted to me that 'we don't see things as they are, we see them as we are.'^{18(p834)} Entering into this thinking about my own ways of being allowed me to be more patient with my client in our following sessions. This outcome is echoed by research from Fisher, Chew and Leow¹⁹ which suggested that therapists who used personal reflection in their ability to understand themselves could attune more fully to their clients and their clients' distress.

This experience showed me just how much my own personal beliefs can get in the way of the therapeutic relationship and also the importance of self-reflection in maintaining a full presence for clients. This issue was highlighted by Bolton⁴ when discussing Smyth's work when he stated that being able to bring the personal into the professional serves to strengthen and increase empathy between the client and the professional.

'Endings' – terminating the therapeutic relationship

As I approached the end date of my first placement I began the process of finishing up with my clients and ending our therapeutic relationships. Although I had only been in the service for a short time, some of my clients had made considerable progress, with one client reporting feeling extremely pleased on his progress when hearing on the reduction in his scores on the BDI-II. I had underestimated how hearing this information would affect him. So often we can take psychometric measures for our own use and overlook the impact for the clients in giving them feedback on the same. I too was amazed with this result, and felt a sense of accomplishment for myself in having helped him on this journey along with pride for my client that I had not expected to feel. When we parted ways that afternoon I knew I would remember this client and such a positive experience throughout my career.

The process of giving and receiving gifts at the end of therapy has also made me think at length about the significance of endings. For one client I had to return a gift, and worked hard on doing so in a way that was not invalidating of the gesture but rather recognizing the importance of what the client had brought to the therapy too. For another client I accepted the gift on the basis that it appropriately validated her wish to acknowledge the importance of the work that we had done together. A study by Brown and Transgrud²⁰ found that when psychologists perceived that the gift being given as inexpensive, informed by cultural context, and presented with gratitude for good work at the end of psychotherapy, they were more likely to accept the gift.

Receiving these gifts made me reflect on my own personal experience of being given gifts in the past. As an only child, I received presents from most family members at birthdays and Christmases. They would usually insist that I open them in front of them and await my reaction. As a result my response would be to put on a show of delight, regardless of how I felt about the actual gift. I was always conscious not to offend them as they had gone to such effort. Receiving gifts from clients, although in a completely different context, activated my internal instinct to respond with the same script. These dilemmas are debated in the literature, albeit not too frequently. A study by Willingham and Boyle²¹ found

that Clinical Psychologists on the whole viewed gifts as powerful objects that warranted acceptance. In this study accepting gifts was thought of as a culturally authenticated response, especially to 'small' gifts. These findings built on previous research by Knox and colleagues²² and Spandler and colleagues.²³ However, some research, including Brown and Transgrud's²⁰ work, is based on case vignettes of what psychologists perceive they would do in a situation and so does not reflect real world results to a greater extent.

The feedback I received from my supervisor at the end of placement gave me faith for the future with regard to my own competence and confidence as a Clinical Psychologist. She stated in review that my 'natural capacity to build therapeutic relationships' was a real strength. This experience helped me to feel confident in my skills going forward in thinking that no matter what population of people I am working with, be it in an adult mental health, intellectual disability or older adult service, they will always just be people in distress and being able to form a strong therapeutic relationship with them will guide us in therapy.

CONCLUSION

Writing this article has afforded me the opportunity to pause and reflect on my experience of clinical training thus far, and my development as a Clinical Psychologist to date. Keeping a reflective journal has been important to me in taking regular time to synthesise and formulate my experiences as a developing clinician. It has been interesting to compare my experience of engaging in personal

development / therapy work independent of the course, using this as a medium to reflect and the process of writing this piece. In my personal journal I feel I am able to write in an honest and open manner that may not flow as freely nor as easily when voicing my thoughts to a supervisor or colleague. The process of re-reading has also been an important one for me in seeing on paper my own growth as a trainee. Keeping a journal is a challenging task and one which I, unfortunately, can put at the end of my list when faced with a busy week of tasks.

In all, the value of reflective practice for me in clinical training so far is undoubted and has had an invaluable contribution to my professional development and self-care practice. Working with people who are in distress, or at times quite emotionally dysregulated, has real potential to impact one's personal emotion and compassion resources. I feel that engaging in reflective practice through writing and through supervision is not only an invaluable tool in developing one's understanding of the client's world but also in ensuring a healthy recognition of the impact that therapeutic process can have on the therapist.

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