

# News

## DCP Annual Conference marks profession's success

The distinctive role of clinical psychologists is increasingly being recognised within the NHS and by government more widely, Professor Peter Kinderman told the Annual General Meeting of the DCP on 31 March. The AGM, which was held during the Division's 2005 Annual Conference at the University of Manchester, marked the end of his term of office as Chair of the DCP.

'Over my year as Chair,' Professor Kinderman said, 'we have been consulted by government more than ever before. Only the other day we were asked to comment on plans to combat a possible outbreak of avian flu.'

Highlights of the conference included addresses by Rosie Winterton, the minister of state at the Department of Health, and by Professor Antony Sheehan, who is Director of Care Services at the Department of Health. The DCP's Invited Speaker, Professor Richard

Bentall, addressed the conference on 'The ups and downs of self-esteem: Explorations of bipolar disorder'.

Professor Chris Brewin gave the M. B. Shapiro Award Lecture on 'The role of theory in the evolution of Cognitive Behaviour Therapy'. The May Davidson Award Lecture was given by Dr Ed Watkins on 'Adaptive and maladaptive rumination: The importance of processing style when thinking about negative content'.

Two sessions were run throughout the conference, offering a full programme of symposia, workshops and individual papers. The conference was held as part of the BPS Quinquennial Conference, which brought together the conferences of three other divisions and two sections as well as the Society's Annual Conference and the conference of the Students Members Group.

### Notes to Contributors

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

# Correspondence

## ✉ Clinical workloads

Alan Dabbs' letter (CP46), and replies in CP47, raise the important issue of what is an appropriate caseload for a clinical psychologist. This issue has been around psychology departments and CMHTs (and their previous incarnations) for the last 25 years with little explicit discussion or evidence base, at least in the three departments I have been in during that time. The discussion has often been at the level of huddles of like-minded psychologists mocking the approach of people they disagree with, in much the same way as Bamford (CP47) uses a mocking stereotype of Yorkshiremen. (NB Can we have some guidance as to which 'humorous' stereotypes will be accepted by the editors?)

An open debate to establish the 'general view' would be helpful. My own view is that a reasonable workload lies somewhere in between Dabbs' and Bamford's opinions. Dabbs' figures are clearly unworkable; how do you fit eight hourly appointments into a seven and a half hour day? As Bamford points out, it takes no account of the complexity of assessments that clinical psychologists are required to do in today's NHS.

However, I also find Bamford's opinion unnecessarily cautious. I have known many psychologists book seven patients a day, and if they all turn up (which is unlikely as something like 20 per cent of patients DNA) then they have coped with this without 'being too exhausted to offer anything worthwhile'. However, I don't think many psychologists would see this number of clients every day, as there are many other activities that have to be included in the working week.

A realistic number of clients in an adult secondary mental health setting dealing with more complex cases would be to book six or seven clients on a clinical day. On average one or two of these won't turn up, which provides useful time for admin. I know many psychologists who work to this pattern, see-

ing 20 plus clients a week, without negative consequences for their health or their clients, and managing to do a wide range of other activities as required.

The development of a general view is going to be difficult in our diverse profession with different models of therapy, but disagreements over appropriate workload cause considerable conflict within clinical teams and the issue needs addressing. Could be a good topic for a trainee's research project.

**Martin Fitch**

South Staffs Healthcare NHS Trust

## ✉ No new ideas, no new solutions

I was dismayed to read your editorial in the March 2005 issue of *Clinical Psychology*. First, you are using your formal position to promulgate a personal view that is clearly antagonistic to the Division's current aims and objectives. I have no objection to your having a contrary view and would encourage you to express it, but as an individual member of the Division not as editor of our house journal. Second, a strength of the journal, and one that you yourself promote, is that it is edited by a collective. Are these the views of the collective – which by logic such an editorial should be – or are they simply your opinion? If this is not their agreed view then by using a route unavailable to others you are, effectively, abusing your position as editor. Third, I would suggest that your argument is entirely misguided. You are not comparing like with like when you are comparing the work of the editorial collective with that of the Division as whole.

Publishing a monthly journal, with its regular schedule, its predictable timing and systematic processes, is entirely different to the daily, unpredictable, complex demands made on the Division officers. The nature of such demands, made on the Chair in particular, is such that to expect a volunteer (or a

collective) to represent the profession at national level nowadays is simply ludicrous. I know that in my time as Chair – when the demands were growing but were less than they are at present – my day job suffered and the time needed for being an effective chair was inadequate, despite the intrusion of Division business into evenings and weekends.

Your last paragraph offers no new ideas, no new solutions. You seem to be suggesting that the new structure will somehow obviate the need for volunteers and that full-time officers will, simply because of their new position, generate more work. The work generated is not a function of the office-holder, whether paid or not – it is a reflection of the world out there – and our desire to influence it, hopefully for the better. The DCP, both locally and nationally, has always called for and been grateful for volunteers. The appointment of a very small number of paid positions cannot substitute for them. It may be that there will be less need for volunteers to do the process work which will allow more time for the broader policy debates that we need.

You note that senior NHS clinical psychologists no longer have the time - how does your suggestion change that? You also suggest that by paying officers then there is a risk that those who 'keep the show on the road' might be overlooked. Currently, with a small and enthusiastic group of volunteers and active support from the Leicester office staff, the DCP makes great efforts to consult and to represent what is a diverse set of views at a national level. How could relying on a more volunteers make that task easier or more inclusive? There is at least as much danger of lack of accountability and inadequate consultation in your model as in any other. Restructuring and reorganising the DCP might allow the opportunity for people to become more involved in the work of the Division and might make it easier to consult and to create policy collaboratively.

I believe that we are a profession to be taken seriously – not in a pompous or self-aggrandising way – but because I believe that what we have to offer to our patients, our

clients and the organisations which employ us is of considerable value in helping them achieve a better life and a more humane service. If we have to pay a bit extra for a more efficient DCP to achieve that for them then, as far as I am concerned, it's a price worth paying.

**Peter Harvey**

Eldwick Beck, West Yorkshire

#### ✉ **The shortcomings of doctoral research**

Ian Kneebone's correspondence (CP48) regarding my article on the shortcomings of doctoral research was welcome and I broadly agree with his view that the scientist-practitioner role is not necessarily defined by being research active.

However, if all clinical psychologists do in the main is evaluate the research of others, then they become mere spectators rather than active participants. This is problematic as it is then difficult to forge new areas for research or address the shortcomings of often inadequate methodologies for evaluating psychological interventions such as randomised control trials (Salkovskis, 2002).

Additionally, Ian Kneebone emphasises the 'challenging' nature of doctoral research. I agree that it is challenging, but the point I originally made was that it is largely challenging for the wrong reasons and can end up being aversive as a result.

Given the pressures inherent to the role of the clinical psychologist working within the NHS, practitioners must be able to see the value of using their research skills to best effect. If the process of acquiring those skills was more rewarding, they might feel more inclined to engage in research after qualifying.

**Mike Smith**

by e-mail

#### *Reference*

Salkovskis, P.M. (2002). Empirically grounded clinical interventions: Cognitive-behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural & Cognitive psychotherapy*, 30, 3–9.

✉ **What it means to remain professional**  
Michael Heap (CP48) seems to be having difficulty understanding what it means to remain 'professional' in our communication with clients: being professional means that we don't burden our clients with our own problems.

Friendships may be reciprocal in this more fundamental sense, but not the psy-

chotherapeutic alliance which is qualitatively different. This, however, does not mean that it diminishes our capacity as human beings to respond to a client's death, as I hope my article made clear.

**Dr Stephane Duckett**  
Clinical Psychologist, Royal Free Hospital

## Division of Clinical Psychology: Honorary Communications Officer

Expressions of interest are invited for the position of DCP Honorary Communications Officer (formerly known as the 'DCP Press Officer'). The post is available as a co-option to the end of the current term of office (April 2006).

The DCP Communications Officer sits on the DCP Executive and Full Committees and is responsible for taking a lead on internal and external communication for the Division. The role requires attendance at DCP Full and Executive Committee meetings (six meetings per year), the annual AGM, and the Communications Subcommittee (four meetings per year).

Practical work involves overseeing the production of media releases about DCP events and publications, providing media advice to the organisers of the DCP Annual Conference and developing new ways to raise the profile of clinical psychology with the media. A more complete job description is currently being prepared.

The DCP is prepared to recompense employers of the postholder up to the equivalent sum of £6,050 per annum (calculated as 0.1 FTE of an nominal salary) to reflect the time commitments anticipated. The Division is also able to reimburse travel and subsistence for attendance at meetings, and covers the cost of attendance at the AGM and Annual Conference. The post is available on a job-share basis.

Statement of Interest forms are available from Lesley Dexter, DCP Co-ordinator, at the Society's office (e-mail: [lesdex@bps.org.uk](mailto:lesdex@bps.org.uk); Tel: 0116 252 9903)

Closing date for the return of the forms is Friday **27 May 2005**.

# Editorial: Racism, diversity and responsibility

Anna Daiches & Laura Golding

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IN THE ROCHES' rarely heard masterpiece *Everyone is Good* (1989) Terre Roche plainly states that 'nobody's god says "hate thy neighbour".' Fifteen years later and it seems that everybody's god/president/pope/prime minister is advocating the hatred of some part of our global community. Leaders of countless countries are whipping their electorates up into a frenzied sense of Us, while fuelling mistrust and fear of Them. This intolerance of difference is, of course, leading to absurd levels of violence where our group identity can serve as our death sentence.

In the UK we are becoming increasingly polarised. We proudly point to our achievements such as the Race Relations Act (Amendment) 2000. Yet the same government that pushed that legislation through has passed legislation that denies asylum seekers their basic human rights. We are the home of the BNP, Ukip, the England First Party, all of whom are attracting votes and accruing political power. We live in a society where 'recreational racism has become utterly endemic' (Sheriff Michael O'Grady, BBC News, 10 August 2004). The police force, the NHS and the Football Association have all uncovered institutional racism.

We talk the talk of tolerance but we simply don't deliver. And tolerance is not acceptance. While all parties chase the pink pound with promises of gay and lesbian marriage, one in three gay men and one in four lesbian women have experienced violent attacks because of their sexuality (Mason & Tamsen, 2001). We happily champion our lovable Graham Nortons but we are still a society that nurtures individuals who feel strongly enough about Them to plant a bomb in the *Admiral Duncan* pub. We can chose to call those individuals bad or mad or we can take a long hard look at the society in which they developed their views.

Clinical psychology as a profession is guilty. Our knowledge base is founded on the notion of difference. We are dedicated in our quest to discover and define endless disorders and syndromes, convincing as many people as possible that they have become *them* and urgently need our help so they can, once again, join *us*. We smother meaningful debate with hollow political correctness and watch as each inoffensive word we create inevitably becomes another derogatory term. It certainly keeps us in work. We sit on the political fence while even the police force is making a stand against organisations like the BNP. And if we think our profession is not rife with racism and discrimination we are deluded. We are comfortable and complacent, exclusive and excluding.

This special issue of *Clinical Psychology* attempts to get under the skin of racism and discrimination. It was conceived by clinical psychologists working in the North West of England as a direct response to the rise of the BNP in Lancashire. A call for papers nationally prompted a wave of submissions. The content of many these is testament to the fact that our profession is no less guilty of being racist than any other. Here you will read clinical psychologists' own stories of the racism they have endured, criticisms of the

## A note on terminology

In line with the policy set out in the Society's *Style Guide*, *Clinical Psychology* generally prints the words 'black' and 'white' without initial capitals. In this issue we have decided to follow individual authors' wishes, tidying up their usage where necessary so that it is consistent within papers.

One or two contributors put the word 'race' in inverted commas, but their usage was not consistent and we decided not to adopt this convention.

Craig Newnes

profession as well as examples of good practice and a search for truly meaningful solutions. We wish to thank all our contributors, particularly those who have had the courage and conviction to write about that which makes us feel the most uncomfortable and which we work hard, so much of the time, to avoid. This is a special issue designed to inspire and ignite not only debate but action.

It might be hard for our profession to argue that 'everyone is good', but surely it is

about time for us to stand up as a profession and say that everyone is equal? More than that, it is time for us to commit ourselves to actually achieving that equality, both within our profession and within our communities. We have a responsibility.

### Reference

Mason, G. & Tamsen, S. (2001). Engendering homophobia: violence, sexuality and gender conformity. *Journal of Sociology*, 37.

## Race & Culture SIG: Call for Volunteers

If you are passionate about addressing racism, prejudice and discrimination and its effects both in society and in our profession and ensuring that our profession is culturally and contextually competent we are looking for people who would be interested in becoming an active member of the National Race & Culture SIG. By becoming a member you can become involved in or support initiatives such as responding to governmental and health documents, responding to BPS and DCP proposals, organising and providing training and conferences; co-ordinating with the regional race and culture SIGs, liaising with the DCP and BPS, developing or contributing to the newsletter and website, providing administrative support, and dealing with membership issues.

We already have an existing loyal and committed membership and we are looking to expand and increase our influence within the profession. We are hoping to attract all levels of the profession but are particularly looking for people in senior and or academic positions.

In addition if you are already involved in or know of a group that looks at issues around race, culture and diversity in your region please could you contact Rekha Vara, Secretary for the National Race & Culture SIG as we are looking to create a co-ordinated national SIG that can work together to affect change.

For either of the above please contact Rekha Vara, Secretary to the National Race and Culture SIG on: rekha\_vara@hotmail.com

For queries about membership please contact Kian Vakili, Membership Secretary to the National Race & Culture SIG on: 020 7609 3291 or raceandculture@mail.com

# Psychologists Against Racism

Ian Fleming & Anna Daiches

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*The origins and focus of a group of psychologists in the North West of England are described, together with the importance for psychologists in understanding the pernicious effects on psychological well-being of racism and fascism.*

**P**psychologists Against Racism (PAR) was formed in the North West of England in the summer of 2003. It is a loose association of clinical psychologists who want to counter the growth of racism locally. Its formation came about after conversations between a number of individuals who were increasingly concerned at the election successes of the British National Party (BNP) in the North West of England, most notably Burnley, in 2002–3. The threat posed to communal living and psychological health by the BNP, and similar organisations is graphically described by the organisations that monitor the politics and activity of the far right in the UK (e.g. [www.searchlightmagazine.com](http://www.searchlightmagazine.com), [www.anl.org.uk](http://www.anl.org.uk)). This paper describes PAR, its activities to date and some of the key issues relating to psychology and racism.

## **Why did we form PAR?**

PAR does not have a formal membership and meets every three to four months. An open letter about the group was circulated to all the clinical psychologists in the North West of England in April 2003. It was well received and resulted in many messages of interest and support. There have been no recorded messages of opposition to the initiative to date.

The election of overtly racist councillors in Burnley and Blackburn in 2002 and 2003 acted as the key stimulus for the organisation of PAR. Members of PAR are concerned about this for a range of reasons. As well as being concerned for the future of community relations in the areas where the BNP and other fascist organisations are active, we are

also concerned as psychologists about specific effects of this. These include increased stress and resulting psychological pressures on asylum seekers, the psychological sequelae of racism, and the question of how individuals experience having a political representative who expresses hatred towards them or their friends, workmates and neighbours (e.g. Burke, 1984; Fernando, 1984; Landrine & Klonoff, 1996). It was our view that psychologists should address these issues through a variety of means and roles, such as in our capacity as activists concerned with human rights issues or as action researchers.

We are also aware that the issues of racism, bigotry and lack of diversity do not just exist 'out there' but are very much present in our increasingly homogenous profession. We belong to a profession that carefully guards its exclusivity and continues to take pride in its apolitical stance.

## **What does it do?**

We have tried to avoid meetings and have met on only five occasions since May 2003. Participants bring different knowledge and experience to our discussions and every attempt has been made to steer these into activity. We have close links with the local DCP Race & Culture Special Interest Group, but our position outside the structure of the BPS allows for an overtly political stance and an emphasis on activism. There are no assumptions that personally, or within our departments, we necessarily represent models of good practice. What PAR believes is that as a profession we need to work together to address the serious impact of racism and bigotry both within our profession and the people we work with. There have been three areas of work so far.

## *Community psychology*

This focuses on ways to utilise community initiatives to address racism and diversity issues.

Although there is little to report as yet, discussions have centred on ways in which psychologists can support communities to work together to address their needs and so undercut the inherently divisive solutions offered by racist parties. Can we learn from community and social psychology in how to reduce division and stereotypes? How can psychological knowledge be used to empower communities?

#### *Input into clinical psychology training programmes*

This involves considering what actions the clinical psychology training programmes need to take to promote diversity within the profession and address the need for training on diversity. This needs to incorporate the entire training programme (placements, academic work and so on) as well as specific teaching. We have designed a questionnaire, in the form of a semi-structured interview, to disseminate to trainees and course organisers in the North West. The questions are designed to find out people's opinions and impressions about the extent to which current training addresses issues of culture and the impact that the training has on the way that they work.

#### *Meeting with psychology departments*

This focuses on awareness-raising amongst clinical psychologists and colleagues post-qualification. A postal questionnaire is being sent to heads of departments, services and speciality asking for information such as referral demographics to gain an overall picture of how culturally aware and able departments in the North West are. Once this information is available, strategies of addressing any need for improvements will be implemented. These include workshops and training (which historically are generally the most poorly attended CPD events even when free to participants). Another role for this subgroup is to disseminate examples of good practice around departments.

Psychology departments should be aware that, under the Race Relations Amendment Act (2000), we have a specific duty to monitor the effect of services on different racial

groups. We must keep detailed data on the use of services by different racial groups. Another legal requirement is that services make information available for and consult all racial groups. It is also a duty that staff be trained on their general responsibilities under the Race Relations Amendment Act (2000) to promote race equality and good race relations and to eliminate unlawful racial discrimination.

It is possible to argue that the above duties are the responsibility of trusts rather than departments or individual practitioners. This is another exercise in passing the buck. There is no reason why we should be dragged into delivering equitable and accessible services when, in the group's view, this is a moral and ethical obligation as much as a legal one.

#### **Why psychologists?**

It was never our intention to be exclusive. Comments have been made about why we chose to address our concerns as psychologists, especially when there are (it is good to report) many other more generic anti-racist organisations in the North West. We thought that, pragmatically, there may be an advantage in identifying our group with our profession as a means to encourage colleagues to make a commitment and develop their activity. As psychologists we inhabit a privileged and powerful position in our society and we work with many client groups, many of whom are vulnerable. Obviously, we are not the only profession to inhabit this position, but if we begin to allow the diffusion of our responsibility it can lead to inertia. It could be argued, therefore, that we have a specific responsibility as a profession to seriously address issues of racism and prejudice that pervade our society. As well as this argument for our responsibility as a profession, the parameters of our roles make us ideally suited to take this challenge on.

Nimisha Patel (2004) states:

To develop and to demonstrate competence in empowerment clinical psychologists need to be able to operationalise a social and political analysis of culture and racialism oppression in their psychological thinking, as well as

in their assessment, intervention, training and research skills (p.120).

### Key issues

At the beginning we addressed the issue of the legitimacy of our activities. We are aware that the profession of clinical psychology is often reluctant (claiming inability) to take any position regarded as 'political'. Whether this is itself reasonable for a discipline concerned with human thought and behaviour both individually and in groups is another issue, but it is of interest that our relations in other professional fields feel less restricted. For example, in January 2003 the *British Medical Journal* had an editorial identifying the effects of racism on mental health (BMJ, 2003).

We have searched mainstream journals from our profession for similarly polemical and involved reports. We have found one from the American Psychological Association (APA) describing the organisation's commitment to combating racism, and in particular, in identifying the 'critical role of psychology' in doing so. The APA delegates to a 2002 United Nations conference on racism stated that psychologists can draw on their knowledge of areas such as child and adolescent development, cognition and trauma recovery to combat racism. One of the delegates said:

This really opens the door to engage in lots of new types of activities that they're uniquely qualified for. For example ... how do we socialize people for tolerance and cultures of peace? How can psychologists contribute to curricula for that (APA, 2002)?

Notwithstanding this, clinical psychologists are recommended to address social context in all aspects of their practice. For example, the Division of Clinical Psychology in its document about services to minority populations states:

Clinical psychologists with both their knowledge of psychological distress and well-being and the inextricable links with contextual socio-political factors ... [should] consider, challenge, and account for the impact of such

factors (including cultural differences and racism) on psychological health ... It is clear that the effect of racial discrimination which emanates from social and economic processes is deeply psychological in nature, affecting the psychological health of the person. Therefore a detailed assessment should include the following: an analysis of the impact of the socio-political context on the client, families and community, including the effects of racism, discrimination, disadvantage and minority status (DCP, 1998).

In our view these comments should not be limited to minority populations alone; racism has different, but significant, effects on members of majority populations too. Also, in its guidelines for Continuing Professional Development (DCP, 2001), the DCP identifies an understanding of racism and its effects on psychological functioning and on clinical practice as core competencies (section 6.8).

It is clear that psychological practice should acknowledge and formulate the pernicious effects on psychological health of people belonging to an openly racist political party with a long history of associations with violence. It is legitimate to take on racism theoretically and practically.

Indeed we have a duty to do so for a number of reasons. First, the political misuse by racists of data and research about intelligence and racial differences. Second, our ability to formulate why individuals may be drawn to political scapegoating and violence. Third, our knowledge of how cognitions and behaviour can change. Finally, our knowledge of the psychological effects of the experience of racism.

The predominant models in clinical psychology may not seem to offer much at first, but we have also drawn on community psychology (e.g. Kagan & Burton, 2001; Thomas & Veno, 1992) and social psychology in developing our understanding of racism locally and in thinking of how to counter it.

### Final thoughts

PAR is not interested in retaining an exclusive membership. We welcome the involvement of other interested professionals

working in similar fields. Similarly, those from different localities can add their voice via e-mail without necessarily attending meetings. We are aware that other similar groups may exist around the country and would be happy to share ideas and strategies.

As well as our professional roles and responsibilities, it is important to use PAR to encourage all of those who can to become individually politically active in their locality in order to stem the tide of the BNP. Apathy,

as in Burnley, wins the BNP seats, activism, as in the Ribble Valley, keeps them out.

### Affiliations

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Anna Daiches: Lancashire Care NHS Trust

### Address

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ian.fleming@nhs.net

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# Health Psychology Across the Lifespan

Division of Health Psychology Annual Conference 2005  
7–9 September; Coventry University

The keynote speakers will be Professors **Neil Weinstein** (Rutgers University), **Beth Alder** (Napier University) and **Pascal Sheeran** (University of Sheffield)

**For more details see [www.dhp2005.org.uk](http://www.dhp2005.org.uk)**

# The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees.

Funke Adetimole, Taiwo Afuape & Rekha Vara

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*Three female clinical psychologists who identify themselves as Black and who qualified from the same course at different times within the last two years reflect on how insidious racism impacted on them as Black trainees. The paper outlines key experiences and provides recommendations for training courses, professional bodies and all clinical psychologists.*

*This article is dedicated to a beautiful person, Adewusi Adetimole, who will be missed greatly.*

**W**E FELT THAT the process of writing this paper was central to the content. Therefore we present the following reflections in order for the reader to bear them in mind whilst reading.

Despite the enormous relief and sense of achievement, there was also a significant amount of secrecy and cautiousness surrounding this endeavour. We did not want to be misunderstood as betraying our course, peers and tutors, as some of them were supportive. As Black people we often have to be very careful about how we talk about our experiences, because of our hyperawareness of other people's anxieties, feelings of guilt, anger or suspiciousness towards us.

On the other hand, we were conscious of withstanding such pressure to use sanitised language that would be more digestible to our audience by, for example, giving 'concrete examples'. We did not want to give fire to the defensive tendency to dismiss experiences not easy to name or explain, or to do all the thinking for the reader. We have considered that this paper might position us as 'having a chip on our shoulder', or 'making

something out of nothing'. However, we feel more and more robust in our ability to defend the positions we take, and the tendency for wanting to apologise for our views has dramatically lessened.

The aims of this article are threefold:

- to facilitate an understanding of how insidious racism works and its impact on the experiences of Black trainees on clinical psychology training courses.
- to present a framework for understanding our survival during training and to challenge the view of us as victims.
- to validate the potential experiences of other Black trainees reading this article.

## **Insidious racism**

Because of the often extremely subtle ways in which racism manifests itself, Black people often have to be hypervigilant to the nuances of communication that can accompany racist thinking. However, these insights, if expressed, can be easily pathologised as draconian, extreme or without foundation. The micro nature of insidious racism can be much more disempowering than its more overt form. Although such subtle actions, ideas and behaviours are manifestations of much larger issues, they are often harder to challenge, and it becomes extremely difficult to explain that micro does not mean trivial.

## *Black people pathologised*

Black people continue to be defined with respect to difference, damage and deficit. Not only does racism ensure an association with everything negative, it also ensures that Black people's experiences are simplified. Such associations with 'disadvantage' and

'the other' were also evident during our training. If the focus was not on trying to understand our difference, it was to examine our oppressed existence. While Whiteness escaped without scrutiny, its presence and influence was always heavily felt by us.

### *Black identity development*

Our development as Black trainees whilst on the clinical psychology course seemed to mirror many proposed models of racial identity development (Cross, 1995; Phinney, 1989). Such models challenge the presumption that Black identity is a stable personality characteristic that can be measured. Despite some weaknesses, such models are useful in understanding the process of reconnecting with and declaring who we are in this world, privately and publicly. Expanding on these models to make sense of our common experiences, we have used the ideas of *conformity*, *disagreement* and *re-establishment*. Rather than needing to integrate our various experiences, as in the process of identity development our process involved re-establishing our previous identity as Black women, that we felt training had stripped from us. Rather than a linear process, we experienced this as cyclical, with each movement through conformity to re-establishment, bringing us to a deeper sense of our personal and professional identity.

The idea of *conformity* refers to the ways in which we initially embraced the strong dominant group values in order to form relationships with our peers. Prior to training, we were outspoken and confident with strong ideas and passions that were important to us. In order to survive the course we soon learnt to conform, and despite our many qualities, unique perspectives and skills, the eventual result was silent trainees, stripped of their identity.

Eventually we began to *disagree* and question the identity-erasing aspects of training. However, we experienced a significant lack of understanding of our experiences, and of our different (non-Eurocentric) perspectives. No longer able to stay silent, as well as feeling isolated and disengaged we searched for ways of finding our voice.

It was not until a Black tutor provided us with a space to think about what we were experiencing that we were able to break from our silence and re-engage with the training process. In attempting to become more outspoken, our ideas and sense of ourselves slowly emerged, as we felt able to *re-establish* the complexity of our identity. As Black peers we started meeting, to share our experiences with each other and to validate our feelings.

### **Experiences on a clinical psychology training course**

During our experience of training the disagreement stage seemed to predominate, as we encountered subtle and overt forms of invalidation.

### **Assumption of inferiority**

The assumption that as Black trainees we were lucky as opposed to hard working came through micro-actions and comments. We were also surrounded by comments about how training courses were desperate for Black trainees, assuming our very presence resulted from the course's need to accommodate assumed 'recruitment quotas'. The implication being, that training courses would have to be desperate to offer us a place. The largely unspoken assumption of Whiteness and middle class as the norm, equated with being clever, high achieving and deserving of success. juxtaposed an assumption that as Black trainees we had 'easy markers' or were accepted on to certain highly desired placements because we were Black. Scrutinising Blackness meant that our White peers rarely applied this analysis of race and privilege to their Whiteness.

### **Being invisible and 'the Other'**

#### *Positive Blackness as invisible*

We often felt as Black trainees that the positive aspects of difference were largely ignored. For example, that differences are often celebrated; that some people spend a lifetime trying to achieve their difference; that people may actively reject mainstream culture in favour of opposing subjectivities. Lecture after lecture focused on White people's experience, including White people's experi-

ence of us as Black people, further reinforcing and locating difference within Black people.

### *Black and female as invisible*

This simplified character of Blackness also resulted in its invisibility in discussions of other domains of inequality. Gender analysis replicated a White middle class perspective that erased the importance of race, such that gender became synonymous with White and female, leaving race synonymous with Black and male. The absence of the Black female experience was left unchallenged.

### **Black trainees as ‘struggling’ and ‘needing special help’**

Carrying the burden of the potential anxieties our telling might cause we found it very difficult to approach White tutors and peers. This was exacerbated by not being able to name our feelings and experiences. Our assumption was that for our White peers, any concerns that they raised, would not be racialised, whereas our constant positioning by trainers as ‘the other’, ‘different’ and ‘deprived’ highlighted the potential for example, of being viewed as ‘struggling’, ‘needing special help’ or of ‘being a concern’. Likewise the existence of a special personal advisor scheme for Black and ethnic minority trainees, although a positive effort to support Black trainees, has the potential for entrenching the view that ‘Black issues’ can only be thought about and addressed outside of a White institution. Equally unhelpful was when supervisors and course tutors overcompensated for their positioning of us, by excessive praise, and avoiding criticism, making us feel we had achieved beyond their expectations.

### **Overt experiences of racism**

As Black trainees we were exposed to all sorts of ideas, attitudes and sentiments that we found offensive and prejudiced. Very few of our supervisors were able to reflect on issues of ‘race’ with respect to power and difference within the supervisory relationship, as well as in reflecting on our work and experiences on placement. Some of our peers felt so comfortable in our presence

that they would express racist views, and our silence fed into their belief that their views were justified and acceptable. This silence also impacted on our peer relationships, such that some of our White peers were unaware of our often intense rage, frustration and sadness, or the power of their collective Whiteness.

The disagreement part of our experience during training came with many dangers. If insidious experiences of racism were challenged we risked violating unspoken dominant cultural rules about how to respond to subtle actions and consequently being ostracised, dismissed or penalised. This discrepancy between what we were able to say and what we actually felt did not dissipate over time, but was carried around with us until we were given an opportunity by a Black tutor to name our feelings, experiences and thoughts.

### **Recommendations**

Throughout our training, and since qualifying, Black trainees on courses all over the UK have told us about their experiences of overt and insidious racism which have left them feeling distressed, dehumanised and demoralised about the profession. It is imperative that not only are these voices heard and acknowledged, but also that they are used to facilitate real changes within the psychology profession in general and on training courses more specifically. Based on our experiences, we propose the following recommendations.

#### *Black lecturers*

More Black psychologists should be asked to lecture on training courses, and on topics other than those considered Black issues, so as not to imply that only White psychologists can teach and that, when Black psychologists are asked to lecture, the range of their knowledge does not go beyond Black issues.

#### *Deconstructing Whiteness*

Wong (1994) suggests that White people take responsibility for seriously interrogating their Whiteness and questioning the privileges that are afforded by their race. On training courses tutors could model commit-

ted self-reflection by for example spending time in lectures dissecting and deconstructing Whiteness.

#### *Responsibility of supervisors*

Patel (2004) maintains that the variety and scope of the issues that Black and minority ethnic trainees face could ideally be addressed in the supervisory relationship, as the intensive, interpersonal nature of this relationship lends itself well to exploration of such personal and professional development issues. Patel (2004) further adds that due to the power disparity between trainees and supervisors, it is incumbent on the supervisor to take responsibility for creating a relationship where such issues can be openly and safely addressed, and the Eurocentric influence on traditional psychological theories and interventions can be acknowledged and challenged.

#### *Challenge the obscuring of Blackness*

Training courses should examine the effects on Black and White trainees of psychological literature where Blackness is either absent or objectified. More importantly, courses should include in their curriculum Black psychologists, sociologists and political thinkers, who explore and describe resistance and challenge to racism.

#### *Black as positive*

The legacy of racism and the heavy reliance on Western models of understanding and intervention continues to stifle the practice of psychology. Rather than being viewed as White trainees in Black skin, we feel that our experience as Black women affords us important and unique insights that are useful to the profession. Black trainees have been enculturated into the dominant culture as well as an upbringing entrenched in different worldviews. In addition, we are highly skilled at maintaining dignity in the face of ongoing, insidious racism both in our personal and professional lives.

#### *Normalising experiences*

It is too easy to subscribe to a view of how Black trainees should be – for example that

we should be able and willing to describe our experiences in ways that are most palatable to others. However, we found it invaluable to have trainers who normalised our behaviour, conflicts and frustrations. In understanding why, for example, some Black trainees ‘keep their head down’, it is important not to underestimate such behaviours or define them with respect to deficit. They are clever inventive strategies employed for survival and they signal resilience.

#### *Attracting and retaining Black clinical psychologists*

At one point or another, each of us thought seriously about leaving the training course and the profession, which highlights the weight of institutional and insidious racism. Even after successfully completing our course, we continue to question whether clinical psychology provides us with a sense of belonging without compromising our identity. If Black people are to be attracted and, more importantly, retained in the profession then these issues have to be addressed by all psychologists.

#### **Final reflections**

The fact that our identities are often erased, pathologised or obscured means that we have to reclaim and reinstate our presence. The risk in doing so is that we become defined purely by those experiences, as though being our ‘race’ is all we (can) do. The responsibility should be on clinical psychology as a profession, otherwise, how can we address the totality of human experience, of which racism is a real part, and empower our clients unless we can open up a dialogue about the biases that exist in our profession, professional bodies and training institutions? Although some courses might raise issues at a theoretical level, simply borrowing the language of anti-racism does not necessarily lead to a real examination of insidious racist attitudes and behaviour and can leave prejudices unexamined and unchallenged.

Although we survived the clinical psychology training in the ways outlined, we

would like to acknowledge the other Black trainees we know of, whose only way to survive with their identity and dignity intact was to leave their courses.

### Acknowledgements

We all believe that the process of training would have been much more difficult had it not been for the invaluable support, integrity, validation and genuine warmth given to us by Dr Nimisha Patel. She has been and continues to be an important role model, colleague and friend.

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# Making diversity teaching meaningful

Anna Daiches

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*Three central issues in teaching about diversity are discussed; the stranglehold of shallow political correctness; the problem with the 'difference approach' to diversity and who is qualified to teach about diversity. The tokenism and assumptions of much current practice is challenged.*

**T**EACHING ON diversity is a well documented thorny issue (Goicoechea & Parker, 2000; Simoni, 1996, 1999; McCarthy & Willis, 1995). Many professions and professionals battle with the task of making this a meaningful exercise and not a parade of box ticking. Part of my role as a clinical tutor on the Lancaster doctoral course is to attempt to address issues of diversity within the induction teaching programme in the first month of training. This paper discusses some of the 'thorns' I have identified and suggests a way of understanding these.

## **The stranglehold of shallow political correctness**

As clinical psychologists we pride ourselves on being a liberal, thoughtful and inclusive profession. (We are not in a position to be proud of ourselves, particularly in this area, but that is the subject for another paper.) From trainee to head of department we have mostly learned the right things to say and the right views to express. Often we have done this without seriously thinking about the assumptions and judgements that lie behind the words.

For example, in a recent interaction with a residential care team one of the (all white) members of staff expressed dissatisfaction with one of the children (of black origin). This child was allowed to keep a television in their room when other children were not. The staff member felt that we should really be 'looking after our own' and expressed

this. Yes this comment sent a shiver down my spine, made me feel outraged and angry but it also opened up an opportunity for dialogue. This was an honest comment. The staff member was utterly unaware of the enormity of what they expressed, or that other colleagues may feel differently. A clear need for discussion, information and reflection was identified and is being acted on.

An employee who continues to privilege one cultural or ethnic group over another should not work in any diverse context. In reality, that would rule out almost every job that I can think of. However, there is a responsibility to attempt to address this and effect change before silencing or ostracising people.

As a generally better educated and informed profession we are unlikely to express such a view, but what makes us so sure we are less likely to hold it? Can we really argue that we operate in objective bubbles of equality when we consider the depths of our personally held values? There are examples in our profession everywhere that suggest otherwise. These include the exclusion of fathers from female-saturated child and family services to the English language dominated reception areas in so many departments. In such ways we betray our values and judgements. We are rampantly heterocentric. We are cowardly in our admission procedures to courses, creating a more and more homogenous profession. We in no way reflect the society we are so keen to minister to.

As we know what beliefs we are 'meant to' hold we are often not honest with each other or ourselves about our true values and assumptions. Assumptions are categorisations without reflection. We all classify and we all compare; we could not function if we did not. As psychologists we have made an industry out of this, categorising ever more sophisticatedly that which is different from the 'norm'. Despite philosophers and scientists

from Protagoras to Einstein demonstrating the illusion of objectivity, we often cling to the notion of scientific truth. Our classifications and comparisons do not represent fixed truths and definitions but meanings that we have created under various influences (Maturana & Varela, 1995). Our classifications include value judgements.

If we consider the work of Jacques Derrida (2001) we can recognise that every discourse shares a sign system in which the key structural feature is the code of binary opposites. The concept of the 'soul', for example, derives its significance from its opposite 'body', 'light' from 'dark', 'natural' from 'cultural', 'woman' from 'man'. One element in any binary system is always privileged over the other and these privileged terms 'slip into' the systems that produce social and cultural hierarchies. Whether we like it or not, the way we represent information to ourselves and between ourselves naturally observes this structure of binary opposites. We all have representations of the Other – that which is outside the self, outside one's own gender, social group, class, culture or civilisation. Broadly speaking, all non-Western cultures are seen as the Other of the West, and within Western society woman, homosexuals, people with a disability and immigrants are often seen as the Other. As one element in the binary system is privileged over the other, the most common representation of the Other is as the worse side, the binary opposite of oneself. Obviously, this can lead to the undervaluing (at the least) of the Other, but also of the self – internalised homophobia is a good example of this.

We have to work hard to unearth our binary systems, to deconstruct, reflect and be aware of our beliefs. We also need to be aware of how we use language to conceive, discuss and refine these beliefs. This is hard going (and must be ongoing), especially as we can all unearth values and beliefs that we are not 'meant' to hold. This needs to involve creating safe spaces where such issues can be discussed honestly and with mutual respect, whether that be in a group situation or a one-to-one meeting. This is much easier said than done.

### **The problem with the difference approach to diversity**

A usual definition of diversity is 'the state of being diverse; difference; unlikeness; variety'. This is a brief definition, but it is useful in illustrating two opposite ways of approaching the subject of diversity. What I think of as the 'difference' perspective is that there are groups out there that are different from the observer. A liberal position would be that the perspectives of these groups must be learned, understood and used to make therapeutic contact more successful and meaningful. There is a huge assumption in this that the observer belongs to the dominant groups of their locality. Therefore, in *Clinical Psychology* Lancashire 2005 this would be white, Anglo-Saxon, protestant, female, able bodied, heterosexual and middle or upper middle class. This position suggests either overtly or through inference that it is possible to collate the definitive book on diversity and, if you read it closely enough, you can understand everything about everybody.

The difference approach suggests that the way to understand an individual is to:

- figure out in which ways they are different from the norm, i.e. male and Buddhist;
- take the difference that is furthest away from the norm, e.g. Buddhism;
- seek knowledge about that difference and use that knowledge to understand that person's perspective;
- if one individual is several shades of different you can emphasise the elements closest to the dominant norm less.

This approach strengthens stereotypes, reduces people to a few categorisations and is often fuelled by myths and tokenism. It also fuels the way we conduct research. It would be great to reach a point where, for example, the roles of whiteness, maleness and straightness are examined in relation to blackness and gayness and not just vice-versa. However, the 'difference' approach is easier because it demands less of us and it offers us a structure that can be so welcoming. It is seductive and is often what is expected by those attending

training events on the subject. It becomes more seductive as our profession becomes more and more homogenous. It does, however, maintain an 'us and them' situation. The 'us and them' situation is bad enough in the hands of those who mean no harm but its high profile and continued status is utilised by those who do mean harm. It also encourages the funding of specialist services rather than really moving towards an inclusive and accessible way of practising clinical psychology.

In the above definition of diversity the word 'variety' is also used. I advocate strongly what I would describe as the 'variety' perspective when considering diversity and our clinical practice. This perspective is that we all vary along an infinite number of axes and that grid-referencing people and defining people will always be impossible. However, we all have a natural desire to grid-reference people; it provides us with structure and is a seductive short cut to understanding. To attempt to understand another person it is helpful to consider which grid-references they are focusing on and why, but also which we, as the therapist, are focusing on and why and to try and come to a shared understanding of a flexible and evolving nature.

### **Who should teach about diversity?**

Who on earth am I to teach about diversity? Or who on earth are *you* to teach about diversity? This is again a difficult issue and one that has been with us for a long time. The central question seems to be whether those that have not experienced discrimination or adversity because of their identity are qualified to work with others addressing the issue of diversity. And how much discrimination or adversity needs to be experienced before you are qualified for the job? I myself belong to the majority, but not all, of the dominant groups in Psychologyland Lancashire 2005. My axes of difference, however, are relatively invisible – known by some, unknown by others. So, for some individuals I will represent all the dominant groups and be a fairly typical example of the homogenous world of clinical psychology. For others I will swing between having some natural face validity to address

the subject to being open to the charge of tokenism. It is tricky to negotiate. I know several non-white colleagues, for example, who are always expected to be the individual to respond to any issue around ethnicity even though it is completely outside their realm of experience.

I have not experienced a great amount of discrimination or adversity due to my identity. On the whole, I have spent many years listening to people's erroneous assumptions, but this has only rarely translated into direct discrimination. So who am I to talk about diversity or write about it here? Despite wrestling with this question in the past I am now quite clear about the issue and I return to my rejection of the 'difference' perspective above to illustrate my point. Whoever is teaching or discussing diversity they are but one person with one set of experiences. They may understand what it is like to belong to a minority, they may have suffered greatly because of it, they may be still suffering but they still represent one perspective. Should we give points for how far people differ from the 'norm' and subsequently grade their teaching ability? Or does this suggest that diversity is their business – them over there, those different ones – not us? Embracing a diverse society and profession is everyone's business. Recognising our own difference and prejudice is everyone's business. Trying to understand other people without reverting to lazy assumptions or shallow political correctness is everybody's business. Anybody who takes some time to think about the issues and challenge themselves is qualified to work with others in this area.

The issue of diversity is central to our roles as clinical psychologists and our lives as members of a community. We have a huge responsibility to think and act in a meaningful way to make our services truly effective and accessible. We can shoulder this responsibility alongside our substantial privilege and kick the 'difference approach' to diversity into the pit of lazy science. Or we can continue much as we are, cradling our exclusivity and continuing to define the multitude of ways that those out there really are different to us.

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Morning (10.30 a.m. – 12.30 p.m.)

Committee Meeting (committee members only)

Afternoon (1.30 – 3.30 p.m.)

'Genetics of Addiction' – Dr Marcus Munafo, Lecturer in Biological Psychology, University of Bristol

'Needle Fixation: fact or fiction' – Dr Dick Pates, Consultant Clinical Psychologist & Clinical Director of the Community Addictions Unit, Cardiff

'Is there a role for Eye Movement Desensitisation and Reprocessing (EMDR) in the Treatment of Substance Misuse?' – Dr Helen Cottee, Consultant Clinical Psychologist, Bristol Specialist Drug Service

If you would like to attend, please contact: Lynn Hartshorn, DCP Subsystems Administrator: Tel: 0116 2529529; e-mail: lynhar@bps.org.uk or cattay@bps.org.uk

# Racism and clinical psychology: Has anything changed?

Nimisha Patel & Iyabo Fatimilehin

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*This paper addresses the question of whether anything has changed with respect to racism and clinical psychology in recent years. Our experiences as Black psychologists provide us with frequent examples of racism. Are psychologists able and willing to change?*

IT IS NOW 15 years since we qualified as clinical psychologists, and this special issue gives us the opportunity to reflect on the observation that racism is still endemic in our professional lives and in all spheres of our work. Wherever we have worked we have contributed to the struggle against racism and attempted to develop a more responsible and just psychology in our teams, our training efforts, our research, practice and service development initiatives. We have watched with eager anticipation and ideological optimism the ways in which the BPS, the NHS and our colleagues have engaged with the challenges inherent in our aims to create better services and practice which could meet the needs and the expectations of our multicultural and multiethnic society.

We hope and desperately want to believe that psychologists and psychological services and practice have matured and evolved more sophisticated ways of understanding the issues and of working with the range of Black and minority ethnic people in Britain. At this point in our careers, the question for us is 'has anything changed?' In this paper, we offer our reflections on whether it is time for the profession to congratulate itself on the progress it has made, or whether such a celebration would be premature.

When we were training, we were part of a tiny group of Black and minority ethnic trainees in this country. Unfortunately, the numbers have not risen significantly since

then and continue to be extremely low, given the diversity of the UK population. Most of the reasons given locate responsibility on Black and minority ethnic undergraduates: 'they are not really attracted to this profession'. Questions are not asked about why they are not attracted, and 'what is it about psychology that makes it an unattractive career prospect for them?' If such questions were asked, they might reveal how careers advice given to many Black and minority ethnic undergraduates often actively discourages them from considering clinical psychology as a career and how many Black people actually perceive the profession.

It seems that it is far easier to reflect on factors to do with the undergraduates or graduate applicants themselves than to focus on what it is about us, our profession, our systems, our training programmes, our image and our track record that excludes Black and minority ethnic people. As a research participant (a Black parent) once said: 'psychology has nothing to say about Black people'.

Research and clinical practice with Black and minority ethnic people continue to utilise assessment tools and measures that have not been validated or standardised on the populations focused on in the studies. Reasons given include 'that is the best of what is available ... and therefore it is good enough' or 'what else do you suggest in the absence of any valid measures for this group of people ... we would end up not doing any relevant and useful research at all if we did not use what we already have' or 'I think it's not a problem, I'm not sure that cultural differences, if they exist, are even relevant to a study of this type'.

This situation is compounded when the responses of Black and minority ethnic research participants are judged against the

responses of White participants. We wonder how such research can be considered ethical. Would it be considered appropriate to use a research tool (e.g. assessing levels of religiosity or shame) that was developed, validated and standardised on a specific Bangladeshi population, but translated into English to conduct research with a White, middle-class English sample? Similarly, despite cosmetic changes such as the translation of service literature into various languages and having posters and pictures of people from Black and minority ethnic communities in waiting areas, the psychological approaches that are on offer are usually based on Eurocentric models that are narrowly and inflexibly applied without a critique of their relevance and limitations in relation to Black and minority ethnic people.

When psychologists are challenged, their responses include: 'what else do you think we should be doing?' 'we do take into account context in our thinking ... people misunderstand our models' and 'well, it seems to help some ethnic minorities, and for the others, maybe psychology is not for them'. We wonder if it is acceptable that psychology should be reserved for those who know how to access and use our services. What of the rest? Is thinking about context all that is needed? Does the responsibility to address these issues rely solely with Black and minority ethnic psychologists? Do we not all have a duty to continually make our psychological approaches, practices and services appropriate and accessible to all?

The exclusion of Black and minority ethnic people from the profession perpetuates a situation in which psychological services in areas where the local population is comprised of significant numbers of Black and minority ethnic people continue to serve mainly the White majority population. When asked why that might be, responses include: 'yes it is an interesting issue and we are aware of it, but you know it is very difficult to know what to do' or 'we sometimes get referrals of ethnic minorities but they either don't turn up, or they drop out and that has to be weighed up against the huge waiting lists we have'.

Do long waiting lists mean that we do not have to think about who we are not accessing and why? Do we want to know why Black and minority ethnic clients may drop out, or choose not to attend their appointments? Where is the evidence for the assumption that they have alternative means to address their difficulties? Are we happy to continue systematically excluding people from our services on the basis of their race, culture and ethnicity? Why do we find it so difficult to engage with the notion of offering Black and minority ethnic people a service that can be delivered in their first language (if it is not English) or the option to be seen by a psychologist from the same 'racial' or ethnic group as themselves? What would our own choices be if we had a psychological difficulty and were living in a country in which we have recently learnt the language and we were aware that significant numbers of the indigenous population did not want us there?

Where issues of race and ethnicity are addressed in service development and planning, they are still perceived as an add-on to standard services, and are not regarded as part of generic services. This leads to the ghettoisation of services for Black and minority ethnic communities and locates them mainly in the voluntary sector with no way of influencing mainstream provision. Thus services that specifically address the needs of Black and minority ethnic people are often poorly resourced, and the responsibility for the solutions is left with the victims. Within these services there is little effort made to address the impact of racism and the underlying socio-political and socio-economic factors that we know can undermine psychological health. Instead, there is a proliferation of services, conferences and training events that promote 'cultural competence' and talk about customs, traditions and language differences.

As important as these are, it is also clear that racism is one of the key factors in social exclusion for Black and minority ethnic people. Colleagues have voiced concerns about proposals for services that are specifically developed to meet the needs of a specific

minority ethnic group: 'but it would not be fair to do this for that group and not for others' or 'providing specific services to address the needs of Somali families would be dangerous as it would give more ammunition to the BNP'.

Some psychological services have become active in liaising with and making links with minority ethnic communities as part of conducting 'needs analysis' to inform the development of services. Community work may involve support, psycho-education and other activities. Unfortunately, the evaluation of these activities rarely includes asking the views of the communities on the relevance or effectiveness of what has been delivered. They are not asked if it is what they want or if it is making a difference to the health of their communities. Psychologists comment on how difficult it is to evaluate such work, how difficult it is to 'engage users', how time consuming such work would be, and so on. Are we really saying it is more important to do something regardless of how ineffective it may be? Do we not genuinely want to know what people think of what we are doing and offering? Do we not want to know if what we are doing is actually making a difference, however this is defined by the recipients of our services?

The Department of Health's document *Delivering Race Equality: A framework for action* (2003) is cited by colleagues as evidence of a commitment to improve health services for Black and minority ethnic people. The first building block advocates collecting more information and is woefully inadequate unless we are able to plan how this information will make a difference to service provision. We already have considerable information about the difficulties and deficiencies in the mental health services. Are we to delay action further by collecting more information?

Similarly, the appointment of community workers to do 'community engagement' is a far cry from community development. Is it not time that we psychologists also move beyond community engagement and consider our role in community development and how community development can lead to partnerships which confront the culturally inappro-

priate and racist aspects of existing services? Black and minority ethnic communities want changes in the mental health and psychological services, and we only have to talk to users of services from these communities to learn where we need to focus our energies urgently. Are we to pat ourselves on the back, assuring ourselves that we have made progress in the ways in which we have engaged Black and minority ethnic communities? Or are we prepared to put our energies where change is needed first and foremost—within our services, within our own approaches and practices?

As members of Black and minority ethnic communities ourselves, we and many of our colleagues often ask ourselves how desirable it is to increase access by Black and minority ethnic people to mental health and psychological services, when many of the services they are likely to be offered or come into contact with are so inadequate and (dare we say it?) racist. And we are not exempt from such treatment. Our own experiences as members of a psychological profession include many instances of racism. We have had to contend with the expectations of colleagues that we are experts on all Black and minority ethnic people regardless of their age or cultural background. Are child clinical psychologists generally asked to speak at conferences on services for older adults? Our ethnicity becomes an overriding factor in how we are positioned within the profession. We have had to face additional hurdles in getting ethical approval for our research at both Masters and Doctorate levels. We have asked ourselves whether it is the subject matter of our research (examining issues of 'race' and ethnicity) or our identities as Black and minority ethnic researchers that mean that we have to enter into additional and torturous negotiations in order to carry out our research.

The list of examples could go on, but we are daunted by having to review the current situation. We ask ourselves how much has changed. Our view is that as psychologists we have a very long way to go to meet the challenges that racism poses us. In reaching the conclusion that not much is new, we are not suggesting that there is no evidence of good

practice, and there are some senior psychologists in the profession who are staunch advocates of change. Unfortunately, what we see and hear on a regular basis far outweighs any positive and genuine efforts towards change. In saying that not much is new we also have to acknowledge that we ourselves have been largely unsuccessful in promoting any meaningful and lasting change.

What we see are often more sophisticated, though still transparent ways of resisting change and of denying accusations of racist views and racist practice. If psychology is to move on, we have to acknowledge the extent of racism in our theories, approaches, practices and services, we have to deal with our own racism, we have to listen to the views of Black and minority ethnic users, we have to make concerted and honest efforts to

transform psychology, and not just make psychology and psychologists more adept at evading charges of racism. The question is, are we up to this challenge, and how many of us really want change?

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# Working in the wild, wild West: Experiences of cultural diversity in the USA

Lisa Morgan-Lang

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*Between 1992 and 1996, I worked in the US. I returned with many multi-cultural experiences that shaped my understanding of cultural diversity, discrimination and cultural competence, which subsequently influenced both the way I view the world and my clinical practice.*

The need and rationale for culturally diverse and appropriate mental health services is firmly established and well documented. Kazarian & Evans (1998) propose that culturally appropriate clinical psychology services require three elements:

- adequate representation of students on training courses and hence the workforce;
- adequate cultural content in training;
- adequate services to meet the needs of individuals from diverse cultures.

Progress has been made in providing such services; however, some argue that culturally diverse services in the UK lag behind those of our colleagues in America (Cromwell, 2001). This is a personal account of my experience working in the US in both clinical and managerial roles within child, adolescent and adult mental health, drug rehabilitation and a community-based domestic violence agency. Cultural diversity knowledge and skills were an inherent part of all these jobs. I also completed a Masters degree programme in counselling psychology, of which cultural diversity was part of the formal teaching and evaluation.

## **Social, political and cultural context of New Mexico**

I lived and worked in the state of New Mexico (NM) in the South West of the US. It is one of the poorest and most sparsely populated states. It relies heavily on the military, nuclear research, education, and agriculture for employment. NM is often considered the

poor relation of its wealthier neighbouring states of Texas, Colorado, Arizona and Utah. However, NM is nicknamed 'The Land of Enchantment' and draws many people back, both to revisit and relocate. I found the rugged, arid deserts, vast wildernesses and the warm, welcoming and laid-back *mañana* attitude both inspiring and restorative.

NM has a distinct and colourful history. Threads of Native American, Spanish, Afro-American and Anglo-American cultures co-exist and integrate. Native Americans had lived in NM for over 20,000 years before the Spanish conquistadors and settlers arrived. There are several Native American reservations in NM; one of the Navajo reservations covers 14m acres. However, the reservations are often inhospitable and remote lands, rather than prime farming or real estate land. There are high levels of discrimination, poverty, unemployment, alcoholism, drug abuse and family breakdown on the reservations. Native Americans seemed to be one of the most disenfranchised and disempowered groups in the USA.

The Spanish influence in Mexico and New Mexico dates back to the 17th century. NM was a Mexican province, along with parts of California, Arizona, Colorado and Texas, and the scene of many embittered territorial battles with America. The Battle of the Alamo was just one infamous event in that historical era. NM became an American Territory in 1850 and an American state in 1912. I only became aware of the historical, political and personal significance of different terms of cultural identity such as Spanish, Hispanic, Mexican-American, Chicano and Latino from living and working in NM, not from textbooks. Experiences of openly discussing with people their sense of cultural identity was an opportunity to realise the significance of people defining themselves,

rather than being defined. This also highlighted the significance of culture and race in influencing how people perceive not only themselves but their position, role and influence in the wider society.

NM shares an international border with Mexico. There are a significant number of migrant farmers, workers and illegal immigrants from Mexico. There often existed an uneasy economic and political tension regarding 'immigrants', which at times, led to prejudice and discrimination. While migrant farmers were needed to fill the many seasonal agricultural jobs, many negative stereotypes existed. These were about Mexicans in America draining resources and about American jobs moving to Mexico thanks to the North American Free Trade Agreement (NAFTA); however, migrant workers and their families often lived in appalling conditions with few public amenities, welfare, schools or rights.

NM's state constitution officially says it is bilingual, and one family in three speaks Spanish at home. In addition, there are numerous Native American languages. I was motivated to learn Spanish and while living in NM, I took evening classes. At times it was easier to engage and work with some clients by incorporating Spanish words and relevant cultural concepts into the conversation. Some children in the residential settings responded better to Spanish when they were highly distressed. Nevertheless, language was but one aspect to consider when working in such a culturally diverse place.

### **Cultural content in MA course**

Both counselling and clinical psychology are recognised professions in the US, with accredited pathways for training and entry into the profession. The Council for Accreditation of Counselling and Related Educational Programs (CACREP) uses the accreditation process to promote and ensure universities maintain the agreed standards for high quality and relevant training. At the Masters level, the training must comprise two years' full-time graduate study covering a core curriculum, supervised practicum and an internship. The CACREP core curriculum includes:

- human development;
- career and lifestyle development;
- social and cultural foundations;
- professional orientation;
- helping relationships;
- group work;
- appraisal;
- research and programme evaluation.

Cultural diversity was intertwined and considered in most academic modules. For instance, the cultural specificity of IQ tests was discussed in the assessment and testing module. The lack of cultural representation in research samples and the subsequent universal application of research findings was discussed in the research module. Different concepts of psychological distress and helping relationships were highlighted in the professional orientation module. In that respect, cultural diversity was seen as central in all aspects of working therapeutically as a counselling psychologist, rather than as a specialist area covered in one module at some point in the two years.

Cultural diversity was covered in depth in a specific module under the category social and cultural foundations. The academic module entitled 'CEP 535: Cultural diversity' was 16 weeks long and each weekly session lasted two and a half hours. The aims of the course are given below.

- increase personal self-awareness of one's own worldview and of multicultural issues;
- assist students in understanding the experiences and histories of various cultural groups in the USA;
- promote valuing diversity, rather than pathologising;
- promote learning about the multicultural counselling process;
- relate effectively in cross-cultural situations.

The module addressed these aims in several ways. Activities in the lectures moved between the intellectual and theoretical to the experiential and clinical skills. We were expected to complete assigned readings – both academic articles and fictional works. We kept a personal and private diary to reflect upon our increasing awareness of multiculturalism. We

completed a self-analysis paper as a means of exploring our own identity, our own unique history, our collective history and the pivotal people and events in the construction of our self-identity and worldview. Similarly, we wrote an analysis of a different cultural group in order to develop specific insight into the identity and worldview of another person. We also participated in small and large group non-threatening discussions and exercises. Topics of discussion included, 'first experiences of being different' and 'not knowing the rules of the game'. Finally, we were expected to develop a role-play using Pedersen's (1979) training model to illustrate some of the critical issues in the multi-cultural counselling process.

### **Cultural worldviews**

In hindsight, I now realise achieving the aims of the course was not an easy task. Any discussion of race, culture, oppression and discrimination can be provocative and emotive. It is often safer to keep the discussion on an intellectual and 'out there' level. It is more challenging to ask trainees to reflect on a personal and interpersonal level and to own their own discomfort, especially within an evaluated setting. (We were evaluated on our participation in the process of reflection and learning, rather than on our specific views or experiences.)

Holiman and Lauer (1987) describe worldviews as an intellectual defence mechanism that can act as a powerful and influential filter through which our perceptions and knowledge of the external environment are passed and organised in order to meet the intrinsic needs and expectations of the counsellor. Not surprisingly, clinicians will tend to identify with and work most easily with clients who are culturally similar to themselves. The lecturer began the module by highlighting this mechanism and its relevance and potential restrictions to our learning and our capacity to relate effectively across differences and diversity. The lecturer also promoted the antithetical stance that reality is constructed of multiple and equal worldviews and our ability to move across varying views is fundamental to our cultural

competence. The nature of the group was also a fundamental aspect of the success and value of the teaching module. The cohesion, warmth, respect, openness and diversity within our group enabled members to discuss aspects of culture and issues of difference, ignorance and discrimination that either we had not considered before or had not had the voice or the arena in which to struggle and grasp such issues. Importantly, the atmosphere was one of connecting on a personal level and exchanging feelings, thoughts and experiences, rather than an unbalanced focus on individuals of ethnic minority backgrounds feeling in the position of educating others or of defending their experiences, their identity and their culture.

### **Concepts and definitions**

The module discussed definitions of race, culture, ethnicity, oppression, discrimination and racism and their relevance to the developing self-concept, psychological well-being and mental health and the utilisation of services. Again this was challenging, I identified myself as a white Anglo individual, and other group members who shared the same or a similar identity became aware of the inherent privileges of being part of the majority culture and the collective guilt of past and present oppressive and discriminatory practices. As females, some of us became aware of the impact of being a minority and being treated as inferior. This in turn highlighted to me how dynamic, multifaceted and interactional the construct of self-identity is.

### **Cultural knowledge and processes**

We studied in detail cultural knowledge of various groups, ranging from African-American and Native American to gender and sexuality, impaired hearing, age and class. The lecturer was keen to point out Ponterotto and Benesch's (1988) stance that there are too many cultural groups for clinicians to be expert on several cultures and that at best we should aspire to systematically identify, understand and accommodate unique and differing needs of diverse clients (Burns, 1992).

In addition, the lecturer pointed out that while cultural knowledge is valuable, there is as much individual variation within cultural groups as there is across cultural groups (Carter, 1991) and hence cultural diversity training needs to address the psychological processes of individuals, groups and assimilation as well as providing cultural knowledge of customs, norms, and so on (Betancourt & Lopez, 1993). Hence, we studied developmental stage models of cultural identity such as Cross (1995) and Helms (1984). In doing so, we not only learned about the impact of evolving cultural identity on the self but also about the impact of differing cultures and developmental identity stages on the client's needs and the clinician-client dyad.

During my clinical practicum, a routine question for opening up this discussion was, 'What differences and similarities between us are important in getting to know each other?' A practicum client who was a male, middle-aged Mexican American unskilled labourer came to counselling. He was embarrassed about seeking counselling and about seeing a younger, female clinician, and was initially reticent in acknowledging his fears of being judged. Asking about the differences between us, allowed us to discuss the man's feelings in a respectful and shared manner. The question also allowed us to discuss options such as changing therapist or beginning a tentative but open and honest contract that was reviewed. Upon completing our work together, there was a sense of mutual acknowledgement and respect for our differences and similarities as well as therapeutic change for the client. I admired and highlighted the client's adaptability and courage in moving from Mexico to America and his amazing experiences working in California. We recognised some of the parallel experience of my move from England to America and also the reality of different opportunities for both parties. The client found counselling a rewarding experience in terms of talking and being listened to and in terms of enabling him to reflect upon some of the internalised assumptions that were impinging on his self-worth and belief in his own ability to realistically pursue his ambitions.

Learning about cultural identity, assimilation and discrimination also focused on our own identity and experiences. Thinking about my own experience and feelings about people's stereotypes of being British or their assuming I was American because I was White was a humbling and thought-provoking experience. I quickly realised how onerous the task of challenging stereotypes was, of explaining my sense of being British, or being from the North of England and how easily people generalise from one person to a whole nation. I still vividly remember and value one tutor asking me how I identified myself and what it meant to me being British. The experience was qualitatively and significantly different. Rather than a voyeuristic interest in Britishness, I experienced the tutor as interested in understanding me and acknowledging the cultural differences of my experience.

### **Cultural competence in the workplace**

I was fortunate to have a manager who was interested in my professional development and my experience of living in NM, as well as completing the tasks of my role. The goal 'Improve awareness of pertinent cultures in NM' was included in my personal development plan (PDP) from the outset. Some of the tasks suggested in my PDP are given below.

- attend Spanish language course and incorporate usage on daily basis;
- watch Spanish language programmes on TV;
- read assigned books giving a historical perspective on NM;
- define cultural implications that may arise in treatment planning or clients;
- attend one pueblo feast day and discuss impressions.

Other managers and colleagues were supportive of my desire to be fluent in Spanish and to appreciate the implications of cultural background for clients. Many conversations arose from a genuine and mutual interest of both parties, in learning and understanding whereby difference was acknowledged. 'Naive' questions were asked by both parties, and time was taken to explain and correct

myths and misnomers. Ways of relating and working cross-culturally were also discussed and the benefit of this was often seen in treatment planning and therapeutic interactions.

### The value of everyday life

My everyday experiences of living in NM corroborated and consolidated much of this conscious learning. Many of my friends were Native American, Hispanic, African-American and Jewish. For a period I shared a house with two Native American women. I got to know friends and housemates both as individuals and as part of their families, their culture and their community, whereby their cultural identity was an integral part of their everyday life and hence, an integral part of the time we spent together. I went to people's grandparents' house where only Spanish was spoken. I went to Mexican weddings where *menudo* (tripe) was a wedding meal delicacy. Conversely, I also experienced first-hand banktellers' and waiters' discriminatory attitude when I was with friends from a different ethnic background. Such negative experiences generated several emotions including shock, embarrassment, injustice, anger, along with empathy and respect for my friend. I also felt the dilemma of wanting to address the situation, but recognising the potentially patronising and undermining effect of such actions for my friend.

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### In closing

I feel very privileged to have lived and worked for four years in the State of New Mexico, the Land of Enchantment. In hindsight, I probably arrived with a blinkered, Eurocentric worldview of people, culture, psychology and mental health. The formal and informal learning experiences and the people I encountered opened up the possibility of diverse and equal worldviews. I was afforded the opportunity to both celebrate cultural diversity and to acknowledge the, often adverse, reality of prejudice and discrimination. I came to realise that the socio-cultural context is a core and fundamental part of people's experiences and self-perception and that cultural competence is about learning to think about and work with the inherent psychological processes as well as having cultural knowledge.

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# Why CBT might be painful

Paul Withers

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*The profession of clinical psychology needs to be more vigilant and less insular in order to avoid charges of institutional racism. Our methods of selection, practice and research require close scrutiny to ensure that they are genuinely competent to reflect the needs of an ethnically diverse population.*

**M**OST CLINICAL psychologists appear to be horrified by racism. We watch aghast as television documentaries expose appalling acts of overt race hatred amongst police recruits, or as institutional racism is identified in professions other than our own. We often appear to feel secure in a belief that because many of us abhor racism, our profession is not affected by it. Closer examination may reveal that there is little room for complacency.

At the time of writing, the annual desperate scramble for clinical psychology training places has reached the end of the phase during which candidates complete their application forms. This process essentially mandates that they regurgitate (in as coherent, scientific, humane and thoughtful a manner as possible, of course) the prevailing view of what clinical psychology is and what they think are the strengths and weaknesses of the roles of clinical psychologists. They also have to demonstrate how their experiences to date equip them to cope with the rigours of training.

It is a process in which only the most courageous would question anything fundamental to the profession, such as the models of psychology it adheres to, all of which are honed from over a century of research, debate and practice following almost exclusively the traditions of Western cultures. Moreover, there is no specific encouragement within the application process for candidates to report non-psychological skills or

experiences which may be relevant to their application (such as fluency in languages other than English, or extensive experiences of living in non-Western cultures); instead applicants routinely report lists of their hobbies, with the result that the author has experienced a situation where a candidate with a private pilot's licence attracted more interest than a similarly qualified candidate who had not mentioned on her form that she was fluent in Urdu and Gujarati.

It is perhaps unsurprising that the profession has historically suffered from low rates of entry, and high rates of attrition during training, by non-white candidates (Bender & Richardson, 1990), and that non-white ethnic groups continue to be under-represented amongst qualified clinical psychologists (Department of Health, in press).

Another route into the profession is via the Statement of Equivalence (SoE). This is awarded by the BPS to candidates trained in other psychological disciplines (e.g. forensic or educational psychology) or who are qualified as clinical psychologists in other countries. The SoE thus holds the possibility of making a very significant contribution to the cultural diversity of the profession, although successful candidates are generally no more ethnically diverse than some completing training courses in this country (Department of Health, in press). Candidates are required to complete varying amounts of additional work to demonstrate their competence to practice in the UK.

For some this amounts to virtually the entirety of the work on a recognised training course in this country, with placements, essays and reports of clinical activity being required from the traditional core fields (adults, children, learning disabilities and older adults), in addition to a small scale research project and a research dissertation (BPS, 1999). All of this may be required of

candidates who have been practising for many years in other countries.

It is quite clear that many candidates do indeed require this amount of additional experience and academic work in order to practise in the same way that a course in this country might have taught them to practise. What is less clear is whether it is crucial to the profession that all people within it adhere to essentially the same psychological culture and philosophy or whether in fact having a diversity of thinking and practice might strengthen the profession and equip it better to meet the needs of a wider diversity of clients. The fairness or otherwise of the SoE process has recently been debated in these pages (Seager, 2004; Fraise, 2004). Its purpose and value in a multicultural society also require examination.

### **Doing the job**

Once we have succeeded in demonstrating our competence within the monoculture of Western clinical psychology, we are unleashed to 'help' the public. Historically, of course, this has not meant the entire public: take up of mental health and learning disabilities services by people from ethnic minority backgrounds has been demonstrated to be low (Campling, 1989; Shah, 1995; Emerson & Hatton, 1996).

Clinical psychologists in many services then come under intensive pressure to see clients for as few sessions as possible, whilst still being expected to generate a formulation for each client which encapsulates their experiences in relation to the presenting problem. We might ask how, in this context, we can be expected to come to any meaningful understanding of the experiences of clients from non-Western backgrounds, or indeed, any clients whose lives have been very different from our own, such as those who live in enduring poverty, (Moloney & Kelly, 2004). It would seem to be breathtakingly arrogant to suggest this can be done within the usual time frames of short-term therapy, and equally problematic to suggest that it is not necessary to do so.

Furthermore, Summerfield (2001) has noted the plight of asylum seekers in access-

ing mental health services, commenting that lack of knowledge of cross-cultural factors can lead to misdiagnosis, and that the detached introspection of individual talking therapies is alien to many of the cultures from which they originate. The solutions to waiting rooms filled almost entirely with White British faces will clearly be more complex than achieving access to translation services.

Then there are the clients we do see. How well-equipped do we feel we are to deal with clients who express openly racist views in therapy? Is it a therapeutic non-issue, or might we be justified in pathologising racist clients and addressing their attitudes directly within therapy? The author's experience of working with other professions has illustrated how different they can be: probation officers, for example, will routinely and directly challenge the use of racist language by their clients. At the very least, it cannot be acceptable that our clients may be subjected to racial abuse in our waiting rooms, and yet despite the information sheets which most services now routinely send to new clients, efforts to dissuade racist clients from openly espousing their views are largely noticeable by their absence.

### **Measuring the results**

The methods by which we gather the precious evidence which purportedly forms the backbone of our profession might also be examined for their capacity to reflect the experiences of people who have not exclusively inhabited Western culture. We are informed that the '1++ standard' for research is randomised controlled trials (NHS, 2003), with studies of individual cases apparently occupying the lowest rung on the ladder of acceptable research methods. Leaving aside the fact that all the methods we use derive from Western notions of science, it seems that we are privileging laboratory-like research, often impervious to external referents and thus devoid of consideration of social context, over those methods which might at least allow some possibility of broadening our understanding of cultural diversity. Of course, '1++' research projects are

more likely to attract funding than those adopting 'lower' standards, further reinforcing our monocultural stance and marginalising non-Western clients, both because of our own risk of being incompetent to help them, and because of their perceptions of our cultural insensitivity.

### Conclusion

Despite the horror with which many members of the profession view racism, clinical psychology nevertheless needs to continually examine itself to see where its actions, however unwittingly, might lay it open to accusations of institutional racism.

The insularity of the profession may be illustrated by the liberal and unsmiling use of the acronym CBT in apparent ignorance of the fact that it has meanings other than cognitive behavioural therapy. In motorcy-

cling, it means compulsory basic training; in the language of sadism and masochism, it stands for cock and ball torture. Assuming that we have grasped the one true and universally applicable set of models for viewing the psychological world we might leave people from non-Western Cultures feeling as confused by and excluded from our discourse as would an individual who practised S&M, although with rather less humorous results.

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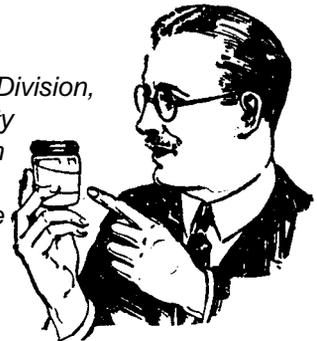
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# Hîwa: Responding to trauma with asylum seekers and asylum seeking families

Rhona Brown, Rupa Gone & Linda Steen

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*In September 2003 a conference was held in Manchester which aimed to highlight specific issues in providing psychological services for refugee and asylum seeker communities. This paper describes the process of organising the conference, emphasising key clinical, professional and political themes which emerged.*

A CONFERENCE, held in Manchester in September 2003, was organised by members and associates of the North West Clinical Psychology, Race & Culture Special Interest Group (NWR&CSIG). Funding for the day was provided by the clinical psychology CPD project of the Greater Manchester NHS Workforce Development Confederation, DCP North West, and the specialist mental health linkworker scheme of Manchester Mental Health and Social Care Trust.

Earlier initiatives identified demand within local clinical psychology services, other providers of psychological therapies and interpreting services for further training in order to respond to the mental health needs of local refugee and asylum seeker (RAS) communities.

Relationships between the London-based Medical Foundation for the Care of Victims of Torture (MF) and a number of local services had been established through the work of MF's Breathing Space regional development programme. MF's plans to open its first regional office in the North West in late 2003 were anticipated with some ambivalence by local services. As a very small service, providing specialist therapeutic work solely with adult survivors of torture, one of its planned functions would be to signpost adults requiring less specialist therapeutic help to local mainstream therapy services. Referrals to

local clinical psychology services were thus expected to increase. Specific challenges to children's services were identified in the increasing numbers of unaccompanied children arriving in the UK and the North West, and their subsequent transition to adult services. At that time, three part-time specialist clinical psychology posts existed in the North West, dedicated to work with RAS communities. However, it was felt that few generic services were likely to have sufficient experience and familiarity with the specific clinical and contextual issues to adequately meet the needs of this client group. It was anticipated that an increase in this type of work would be similarly challenging for local interpreting services, highlighting the need for closer collaboration. It was felt that a training collaboration amongst local psychological therapies services, interpreting services, and MF, would have reciprocal benefits for all parties.

The aims of the conference were:

- to provide basic orientation and information about asylum seekers and the asylum process, with a view to deconstructing commonly held myths;
- to highlight specific issues in the provision of psychological services to RAS adults, children, and families, including specific clinical issues pertaining to trauma;
- to enhance skills and understanding in relation to the collaborative process between clinicians, and interpreters and linkworkers, when working with trauma in the asylum context; and
- to share information about national and local resources for the support of RAS and survivors of torture, with a specific spotlight on MF.

While taking a clinical psychology focus, it was

felt that the above aims would be best met by including contributions and participation by a mix of clinicians, interpreters and linkworkers, and non-statutory agency workers. Free places were ensured for interpreters and linkworkers, non-statutory agency staff, and assistant and trainee psychologists. A total of 105 people attended the event, 50 of whom had a psychology background. The conference attracted fewer interpreters and linkworkers than had been hoped, but more non-statutory agency workers than had been anticipated.

The overall title and theme of the conference, *hîwa* (pronounced 'high-wah') is the Kurdish Sorani word for hope. This was inspired by reflections on Iranian Kurdish asylum seeker Abas Amini's protest against the treatment that he and others had received from the Home Office. Abas stitched up his eyes, ears and mouth for an 11-day period in May 2003. His attempts at resistance in the face of hostile government policy highlighted the necessity for hope in the lives of asylum seekers, whose journeys to the UK often assume a degree of hope which is disappointed by the realities of such policy. It had not been anticipated that the conference would actually take place two weeks after the death of another Iranian asylum seeker, Esrafel Shiri, who set himself alight in the offices of a key refugee support agency in Manchester. His actions resulted from the lack of hope he held in his struggle to remain safe here in the UK, having lost his asylum appeal, and as a result, rights to work, housing, benefits and specialist medical treatment. This tragic local event underlined the importance of the issues being addressed on the day.

The 17 contributors included key MF staff from both its London and North West offices, a range of local clinicians and community development workers, local interpreting and linkworker services, and key local RAS community organisation representation.

Original plans to engage a keynote interpreter speaker fell through at a late stage. In an attempt to redress the resulting imbalance, three-way communication issues were the theme for the majority of morning workshops.

The morning began with an inspiring presentation by Nimisha Patel, head of clinical psychology at MF in London, in which she described her work with RAS survivors of torture. She outlined the common difficulties experienced by RAS and the limitations of psychological approaches to address these (e.g. Eurocentric, individualistic and pathologising). She went on to describe what can be done therapeutically within a human rights context, including a commitment to challenging human rights abuses, rejecting neutrality, taking a contextual approach and attending to difference and power. She ended with a number of challenges to participants – What sort of therapist do you want to be? What sort of psychology do you want to practise? – and highlighted her conviction that to practise a just psychology, therapists cannot be passive bystanders in the face of the health impacts of injustice, but must commit themselves to social action.

Steve Conway, coordinator of multi-agency for refugee integration in Manchester, went on to describe the process and support for dispersed asylum seekers, illustrating that the process is both complex and aversive, as if designed as a deterrent.

Parallel morning workshops (details of workshop facilitators available on request) included the options of:

- Communicating with children in lots of languages;
- Enhanced interpreting skills in mental health;
- Speaking with the silenced: Working with interpreters and refugees;
- An introduction to the work of the MF North West office.

The morning ended with an open debate on the pros and cons of specialist service provision, with different perspectives on this issue offered by Rebecca Hughes, a clinical psychologist working in a generic adult primary care service in central Manchester, Chrissie Verduyn, director of psychological services for central Manchester and Manchester Children's University Hospitals NHS Trust, providing child and family services across Manchester, and Nigel Rose, deputy manager of Manchester Refugee Action.

Alison Harris, head of primary care psychology services at Bolton, Salford & Trafford Mental Health NHS Trust, chaired the ensuing discussion.

The afternoon opened with a keynote presentation by Sheila Melzak, principal community child and adolescent psychotherapist at MF in London. Sheila highlighted key polarities in the experience of RAS children subjected to trauma, emphasising that only a proportion will be traumatised as a result. For those who are, the internal world becomes fragmented, and the therapist's role is to help the child reintegrate their experience and to return to his or her developmental path. She illustrated her own work with children by telling some of their stories through paintings and drawings made at different points in their recovery from trauma.

Ali Namegoshaye Fard, a refugee and member of a Salford-based refugee and asylum seeker participation action research project, began his personal account, 'A window on asylum seekers' lives,' with a minute's silence for Esrafel Shiri. As part of his observations on the asylum experience, he commented upon the idea of a multiplicity of selves in the asylum seeker's mind:

A violent person? To respond to the violence in his life.

A brave person who appears to be an adventurer? To pass the borders and barriers of the countries.

A very great person, much greater than he was, in order to be qualified for granting of refugee status with Home Office standards and expectations.

An optimistic person, he who interprets and judges the unpleasant events in a pleasant way.

A liar who lies to himself and others that things are in order and there is nothing to worry about.

A choice of afternoon workshop options included:

- Sharing clinical approaches and working together;
- The beneficial triangle: Dynamics in interpreting work with trauma;
- PTSD: Its relevance in work with asylum seeker and refugee survivors of torture;
- A practical guide to report-writing for asylum applications and appeals.

The day ended with an open plenary, followed by a summing up. A number of participants highlighted the relative absence of an interpreting perspective, and the need for long-term investment in interpreting and bilingual services. Another participant emphasised that the humanity of the speakers had enabled her to feel more hopeful about working in the field. Ian Fleming, clinical director of the Manchester University doctorate programme in clinical psychology, and consultant clinical psychologist, Pennine Care NHS Trust, then summarised his observations of the day, drawing attention to the political nature of understanding and responding to the psychological needs of RAS, and the use of asylum issues in the racist and violent activities of the BNP around the North West. Ian outlined possible ways forward for local services, training programmes, and the profession more generally. His final comment emphasised the value of the day in developing local networks.

Forty-eight per cent of participants completed evaluation forms, and overall ratings for the quality of the event were high. Much of the day's success was attributed to the contributions and perspectives of MF staff. An important theme, highlighted by a significant number of respondents in qualitative responses, was the degree to which therapeutic work can or should be explicitly political, within a human rights framework. An example of this was an issue raised at several points in the day, regarding the need and legitimacy of providing psychological reports, to the standard required for asylum proceedings, within the context of routine clinical practice. Demand was expressed for further training events, which could develop themes and topics introduced on the day. A strong sense of positive emotion, warmth and supportiveness was expressed in a significant proportion of qualitative comments.

Feedback from MF staff noted the success of the conference in engaging a significant number of participants not already involved in work with RAS; it was felt that *hîwa* had attracted an unusual number of individuals for whom the topic was relatively fresh.

The quality of the event for the small group of interpreters and linkworkers attending was variable. Despite original aims to fully integrate interpreting issues into the day, they had remained marginalised. It is intended that a small unplanned profit from the conference will be used to promote further collaborative training amongst local providers of psychological therapies, interpreters and link-workers. However, the differentials in organisational and professional power between interpreters and psychological therapists are marked and need to be taken into account when considering the structure and process of future collaborative training.

Six months after the conference, the North West saw the inaugural meeting of PsyRAS: Greater Manchester Support Group for Psychological Therapists Working With Refugees and Asylum Seekers. This group has built upon identified professional support needs for work with RAS in the area, in collaboration with MF's North West Office, and with the endorsement of NWR&CSIG. It aims to facilitate reciprocal support and networking amongst providers of psychological therapies working with RAS

clients in statutory settings, via sharing information and resources, organising peer supervision and CPD, holding issue-based discussion and policy updates. A specific priority is to work towards sharpening skills in producing psychological reports for asylum proceedings. The group hopes that once established, it can act to campaign, lobby, and influence local service development. PsyRAS can be contacted via Jake Bowley, Department of Clinical Psychology, Pennine Care NHS Trust, Birch Hill Hospital, Birch Road, Rochdale OL12 9QB.

NWR&CSIG thanks the funding agencies, and the many contributors and participants, who helped make *hîwa* a success. Copies of the full conference evaluation report are available on request.

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## **Society Media Training Days**

*Held at the Society's London Office, 33 John Street,  
London WC1*

**Monday 26 September 2005 ; Monday 5 December 2005**

These days are designed to give an introduction to how the media operates and introduce some of the skills necessary in media liaison: press release writing and interview techniques.

The course fee £99 to society members and £124 to others. For further information please contact: The Press Office, The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR; Tel: 0116 252 9500; e-mail: [mediatraining@bps.org.uk](mailto:mediatraining@bps.org.uk)

# Identifying institutionalised racism in a sexual health/HIV service

Andrew Beck

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*The Macpherson Report (1999) defines institutionalised racism as 'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin'. This study reports on a quantitative study which identified systematic discriminatory practices in an inner-city psychology service.*

THE RACE RELATIONS ACT 2003 states that all organisations, including the NHS, must promote racial equality in access to services. There is a growing awareness of the need for strategic health authorities and primary care trusts to address health inequality issues amongst ethnic minority patient groups, and the recent National Strategy for Sexual Health and HIV emphasised the importance of engaging at-risk and hard-to-reach groups in the community (Department of Health, 2001). Cultural, social and economic variables have been shown to be predictors of access to services, patterns of service use and prevalence of sexual health problems (Low *et al.*, 1997; Lacey *et al.*, 1997; De Cock & Low, 1997). Many previous studies have highlighted disparities in mental health service provision between those available to White British service users and those from ethnic minorities. Compared with White British patients, ethnic minority service users are less likely to receive psychological interventions, preventative interventions or aftercare and are more likely to receive pharmacotherapy and inpatient care or enter mental health services through criminal justice routes (Nazroo, 1998). Black user groups and community organisations have also clearly requested better access to psychological interventions (Wilson & Francis, 1997).

The present study was conducted within a psychology service providing input to a

sexual health and HIV service in an ethnically diverse inner-London area.

In order to facilitate equality of access, sexual health services and the psychology services operating within them must develop culturally appropriate models of service provision and health promotion based on an understanding of the barriers to access encountered by ethnic minority service users. Little is known about the challenges facing patients trying to access psychological services in a sexual health setting; however, it is likely that many issues relating to accessing general psychology services will be pertinent.

When looking at issues of service use it is useful to conceptualise the route into psychology services as a pyramid (see Figure 1), with the majority of potential clients with a need for these services existing in the community on the bottom tier (tier 5). A proportion of those clients will attend a specialist clinic (in this case a sexual health clinic) where they will be assessed by a medic, nurse or health advisor (tier 4). A proportion of these people (tier 3) will have their mental health and psychological problems identified and be referred to psychology services. Some, but not all, of those identified will attend sessions (second tier) and some, but not all, will improve (top tier). At each stage there are potential challenges in accessing and utilising the service and progressing to the next tier of the pyramid in order to be effectively treated and to improve. Cultural factors and institutionalised racism may make progress through these tiers more difficult. For example, ethnic minority patients may not be aware of the existence of specialist clinics or how to access them. Where assessing clinicians are of a different ethnic background to the patient they may be less able to identify distress or believe

that psychology services are not appropriate. The patient themselves may also be less likely to express distress to health professionals in these circumstances. Of those who are referred, the explanation given to them about the role psychology plays in mental health may not fit with their cultural model of distress and its treatment leading to poor engagement. Individual psychologists' inability to work effectively with ethnic minority patients may also lead to poorer therapeutic outcomes for those patients.

## Method

### *Service setting*

The infection and immunity team provides psychology services across two inner city London hospitals to patients in the general sexual health clinic, HIV and sexual assault services. The range of referring problems includes adjustment to diagnosis, adherence to medication regimes, psychosexual problems, anxiety, depression and post-traumatic stress disorder following sexual assault.

### *Sample*

All new patients referred to clinical psychology services over a 12-month period entered the study.

### *Measures*

Clinical psychologists prospectively completed information for each patient during routine clinical contacts. Demographic information, including patient-rated ethnicity, was recorded at the initial session. Due to limited numbers in the sample, patients were collapsed into four categories for analysis: White, South Asian, Black and Other. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was completed for each patient at session 1, 4, 8 and 12. A visual analogue scale was used to record the patient and therapist's rating of improvement at session 4, 8, 12 and the final session.

## Results

### *Sample characteristics*

A total of 318 patients entered the study. The mean age of the sample was 33.7 years (range



Figure 1: Stages of progress towards improvement

17–69 years.) The gender of the sample was 45.4 per cent female and 54.6 per cent male. In terms of sexuality, 44.9 per cent identified themselves as heterosexual, 38.8 per cent as homosexual men and 2 per cent as homosexual women. Using the collapsed ethnicity categories, 71.8 per cent identified themselves as white, 16.4 per cent as black, 4.9 per cent as South Asian and 6.9 per cent identified as other. Forty-four per cent were in paid employment, 6.5 per cent were students and the remainder were on unemployment or sickness benefits.

### *Referral rates to the clinic*

Demographic information about the population of service users of the general clinics was compared to rates of referral to psychology services. At site 1's HIV and GU services there was less referral of Black clients and Other clients to psychology, and greater levels of referral of White patients. At site 2's HIV service referral rates matched the population served, whereas in the sexual health service there was less referral of Black patients and no referral of Other ethnic minority patients despite their comprising 15 per cent of users of this service.

### *Distress on referral*

Chi-square was used to compare HADS scores on referral (collapsed into three categories of case, borderline case and non-case). Overall there was no difference in levels of anxiety and depression on referral however in one of the two sexual health clin-

ics it was found that ethnic minority patients had higher levels of depression on referral than White patients (significant at 0.02, chi-square=11.25, df = 4).

#### *Mean number of appointments offered, attended and missed*

The mean number of appointments offered to White patients was 5.7 compared to 2.9 for ethnic minority patients (significant at the 0.005 level). This difference was reflected in the mean number of appointments attended (5.3 for white patients, 2.1 for EM patients, significant at the 0.05 level) however the mean number of appointments missed (1.3 for white patients, 1.1 for EM patients) was not significantly different. Table 1 illustrates these different patterns of service use.

#### *Therapist and client outcome ratings*

These were recorded at session 4, at session 8 and at the final session. There was no significant difference in subjectively rated outcomes of therapy by clients or therapists between white and the ethnic minority patients.

#### *HADS scores*

HADS scores for depression and anxiety at session 4, at session 8 and at the final session were analysed. There was no significant difference by ethnicity.

#### *Therapy ending*

Significant differences in therapy endings were found (significant at 0.002, chi-square=34.7, df=16). Black clients were more likely to be never seen or to drop out of therapy before an agreed ending. Asian patients more likely to never be seen. Other patients more likely to never be seen. There was no difference in rates of 'ending agreed', 'referred on' or 'still being seen'.

## **Conclusion**

Malanda *et al.* (2001) state that a lack of familiarity with ethnic minority cultural issues leads to less recognition of distress by professionals and less disclosure of distress by patients. This results in lower rates of referral for specialist psychology input for ethnic minority patients. This is partially supported by the present findings, as referral rates are markedly lower in some areas of the service and in some clinics levels of distress may need to be higher before they are identified by referrers. As rates of not attending initial appointments were higher amongst ethnic minority patients and rates of dropping out of therapy were higher amongst Black patients the overall number of sessions offered and attended was lower for ethnic minority patients. Once engaged however ethnic minority patients subjective and objective outcome measures were as good as those for White patients. This suggests that once challenges associated with engagement have been met that successful therapeutic outcomes are likely.

It is apparent that some degree of institutional discrimination existed despite the department having a good record of reflective practice, cultural sensitivity training and a dedicated anti-discriminatory approach to service delivery. This research highlights that such approaches alone are not sufficient to identify unhelpful practices and that systematic, qualitative research is also a valuable tool in identifying areas for improvement and developing non-discriminatory services.

A number of changes to practice are suggested by this research:

- referrers (medics, nurses and health advisers) to be made aware of the need to identify distress in ethnic minority patients more effectively;

**Table 1:** Patterns of service use compared by ethnicity

	<u>White patients</u>	<u>Ethnic minority patients</u>	<u>Significant</u>
Appointments offered	5.7	2.9	0.005
Appointments attended	5.3	2.1	0.05
Appointments missed	1.3	1.1	NS

- referrers to explain the rationale for the referral to the patient in order to minimise initial engagement problems and ensure the likelihood of attendance at first appointment;
- psychologists to be more proactive in engaging ethnic minority patients who DNA their initial appointment and to ensure that patient drop-out rates decrease by using more effective engagement strategies.

Discussion resulting from this study also highlighted the paucity of knowledge about the specific sexual health needs of the largest ethnic minority group served by the hospital. A qualitative research project was initiated which used community participation to raise awareness of the complex social issues around engagement with services faced by this community (Beck *et al.*, in press). Although outcomes research and research involving community participation takes considerable time and resources, services working with ethnically diverse communities have a clear legal and ethical duty to ensure that they are meeting the needs of their communities and to change service provision where it becomes apparent that they are failing to do so.

The present research does raise some methodological problems, most notably the validity of ethnicity categories. To aid analysis, 20 client-indicated ethnicity categories were collapsed in four researcher-rated categories (White, Black, Asian and Other). This

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is impossible to justify epistemologically, but the small numbers of patients in many categories made analysis of 20 ethnic subgroups less meaningful. Future work needs to address this issue more appropriately, although the face validity of the categories chosen are justifiable in so much as they provide meaningful results which were useful to inform service development. Socio-economic class was not recorded in the research. It may be that this is as powerful an explanatory variable as ethnicity. Future research also needs to account for this. Methodological issues aside this approach can provide powerful service-level indicators of discriminatory practice across all teams offering mental health services to an ethnically diverse population and can prove useful information to clinicians and service managers to inform changes to practice.

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DCP RACE & CULTURE SIG ANNUAL CONFERENCE

# Clinical Psychology, Race and Culture: Time for Action

**Wednesday 29 June 2005; Sheffield University, Main Psychology Building, Western Bank, Sheffield**

## *Provisional programme*

Angela Williams (Chair, Race & Culture SIG)

**Welcome and theme for the day**

Rasjid Skinner

**Paradigm Change: Service Provision for BME Communities**

Prof. Graham Turpin (Chair, DCP), Jan Burns (tbc) & Dave Green (tbc)

**Promoting Diversity within the Profession**

Professor Zenobia Nadirshaw

**Supervisory issues for BME Trainees and Clients**

Speaker to be confirmed

**Trainees Experiences of Clinical Psychology Training**

## *Workshops*

**Service provision** – Rasjid Skinner & Jaswinder Laur

**Culturally appropriate training** – Prof. Graham Turpin & Angela Williams

**Supervision** – Prof. Zenobia Nadirshaw and Jasmine Chin (tbc)

## *Bookings*

Please contact Gwen Ward ([gwewar@bps.org.uk](mailto:gwewar@bps.org.uk)) or Cathleen Taylor ([cattay@bps.org.uk](mailto:cattay@bps.org.uk)) for further details and a booking form.

# A quick thank you from the BNP to the BPS and the APA

Anna Daiches

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**T**HANK YOU for Sir Francis Galton (1822–1911). At the birth of your fine science of psychology you were already looking for ways to scientifically confirm the supremacy of the white, western male. The creation of eugenics which Galton told us is ‘the science which deals with all influences that improve the inborn qualities of a race: also with those that develop them to the utmost degree’ was inspirational and hugely influential. Although some less on-the-ball members of society than us feel that eugenics is a thing of the past, we proudly recall The Galton Institute conference in September 1999 when Glayde Whitney eloquently reminded us that

A favourite attack on eugenics is to equate it with Nazis. In various ways a slippery slope is argued: official government sanctioning of eugenic concepts leads inevitably to racism, anti-Semitism, euthanasia, genocide, holocaust and all the rest of it. Confounding eugenics with Nazism has been so successful a tactic since World War II, that many people who are interested in eugenics do what they are supposed to do: hang their head in shame and shut their mouth. However, what should be shouted is that the whole argument is a sham, another falsehood.

As Marian Van Court has pointed out, in the first half of the 20th century, a total of at least 29 countries passed eugenics laws, including Germany, United States, Canada, Switzerland, Norway, Denmark, Sweden, Italy, Greece and Spain. One of these advanced countries proceeded in time of war from euthanasia to genocide. The other 28 countries did not. One out of 29 does not establish a pattern. The post-war propaganda linking eugenics to Nazism and a slippery slope to holocaust is

just that: horrific, continuing propaganda warfare.

Thank you Carl Jung (1875-1961) for making sure that the clinical application of psychology was as preoccupied with the supremacy of the white, western male as its experimental cousin. Suggesting that White Americans had to be more morally rigid than White Europeans to counteract the influence of a large Black population in America was spot on. Now that Europe has become as multicultural as the USA, we advocate the same moral rigidity in many of our campaigns.

Thank you very much for DSM II. Thank you for sticking to your guns and not revising the claim that

Homosexuality is a pathological disturbance in sexual development ... to remove homosexuality from the nomenclature would be to give official sanction to this form of deviant sexual development, would be a cowardly act of succumbing to the pressure of a small but vocal band of activist homosexuals who defensively attempt to prove that they are not sick, and would tend to discourage homosexuals from seeking much needed treatment.

until 1987. This gave scientific backing to the wonderful Section 28 of the Local Government Act (1988) which has protected our children from deviance into the new millennium. We always remember that children are our future.

Thank you very much for the whole concept of Intelligence Quotient. This was genius, although we are quite sure that Binet wasn't aware of just what a masterstroke he had achieved. In your eloquent and rigorous manner everyone from Goddard to Spearman,

from Terman to Yerkes, managed to define the Inferior Individual, a concept that has proved very useful for us. As a profession you recognised that these Inferior Individuals needed to be regulated and, extremely importantly, prevented from reproducing. We now had scientific data to support racism and discrimination. Excellent. What is so great about creating something like IQ is that the data and the evidence just never stop. Murray and Herrnstein's fabulous tome *The Bell Curve* (1994) again made it crystal clear that IQ is largely genetically determined and that the differences in IQ are substantially explained by genetic factors. These great scientific works are so useful when PeeCeEs (a term coined by one of your most celebrated sons Chris Brand) rant on about environmental factors, opportunities, wealth distribution etc.

Thank you for reducing decades of research into personality and intelligence and producing the 'g' factor. Thank you for ignoring all research into social constructs, cultural influence etc. Thank you for sticking to the concept of scientific objective facts in the face of much thought and theory to the contrary. Thank you Hans Eysenck, Richard Lynn, Arthur Jensen, Charles Murray and the charming Mr Brand. Thank you for sticking to the idea that there is a 'g' of crystallised intelligence, a lump of some-

thing inside the brain that differentiates the inferior from the superior. Thank you for ignoring all the decades of research into brain functioning, the complex and numerous pathways and interactions that have been suggested and demonstrated. Thank you for keeping it all so 19th century. It honestly makes it so much easier to argue our case.

We know that we could not acknowledge all your endeavours as a profession in this small article. For those that have contributed greatly to our cause and we have not thanked in person, please forgive us, your life's work is our lifeblood. We also acknowledge the smaller contributions. We know how important the continual strive to differentiate individuals from the 'norm' is, especially when that norm is white, western and male. We thank you all for creating new disorders and syndromes at such a wonderful rate. The more you emphasise difference the more we can persuade people to come with Us and to hate Them. May your brilliance continue.

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#### **Further reading**

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## **Division of Clinical Psychology Faculty for Eating Disorders AGM**

**Thursday 5 May 2005; Room DG117,  
Littlemore Hospital, Sandford Road,  
Littlemore, Oxford**

A day on service development and arising issues with Glenn Waller, Martin Carroll, Christa Schreiber-Kounine, Alex Willner & Eric Johnson-Sabine

Free to Faculty members, Others £10.  
Canteen available for lunch. All enquiries to  
Nicky Boughton – Tel: 01865 226988;  
e-mail: nicky.boughton@oxmhc-tr.nhs.uk

# Mobility of clinical psychologists

The following clinical psychology departments have indicated that they are willing to be approached with enquiries about vacancies which may arise over the next year.

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

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

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

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

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

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

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

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

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

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*To place a new entry – or remove an old one – please write to:*

*Jonathan Calder, The British Psychological Society, 48 Princess Road East, Leicester LE1 7DR; Fax: 0116 247 0787  
e-mail: joncal@bps.org.uk*

# Book Cover

Edited by Arlene Vetere

## **DSM-IV-TR Mental Disorders: Diagnosis, Etiology and Treatment**

*Michael B. First & Allan Tasman*

Wiley, 2004, £85

This massive text, more than 1323 pages long, is the latest APA offering of the codes with which we are to understand emotional difficulties, give the diseased the correct pills, and claim for our time under the correct heading.

There is a certain fascination in examining the subtexts more closely. In the first sentence, we get the authorisation for the claim of the sacred nature of the text: 'The publication of DSM-III in 1980 revolutionized the field of mental health research and treatment.' (So, clearly DSM-I and II have been omitted from the narrative.) Then the folksy explanation of why diagnosis should be so all consuming: 'There is a natural human predilection to categorize and classify for simplifying and organizing the wide range of observable phenomena and experiences' (p.4). There is no conceptual activity necessary in labelling these diseases. They are out there waiting to be recognised. After all, that is how the real doctors go about their business, and no one is going to be able to say that psychiatrists are not doing the same thing. Pity that they keep stumbling over new diseases, making each version ever heavier – the number of diagnoses doubled between 1968 (182) and 1994 (357; Harper, 2001). This volume, being a tidying up job on DSM IV, only has two new diagnostic groups – Amphetamine-Related Disorders and Reactive Attachment Disorder.

What is fascinating is the lack of discussion. Psychoanalytic models of aetiology were long vanquished; other professions' view-



points are absent. A sop regarding psychosocial factors is provided by Axis Four, but this does not feature further. Academic contributions are missing. (For an historical understanding of the relevant battles, see Kirk & Kutchins, 1992.)

Once the short monologue is complete, the listings start. This book expands DSM IV TR because 'it contains a wealth of information about all three of these critically important areas' (p.xxiii) namely, aetiology, pathophysiology and treatment.

Then start 46 chapters of lists to diagnose. I checked out dementia. It is totally out of date. The latest reference is 1993, so for example Lewy Body Dementia, now a well-established form, is absent. The model of memory is ancient, and bears no relation to the huge amount of academic research going on in the field. Any talk of psychosocial factors contributing to memory loss is absent.

Any practitioner would be most unwise to use this book to defend any disputed practice, given its narrow and out-of-date discussion and references. One hates to think how much pain to how many thousands of people has been justified by DSM, and how many possible increases in scientific understanding it has prevented.

**Mike Bender**

DCP Trent Branch

# Professional Issues

**16 May 2005**; BPS Offices, St Andrews House, 48 Princess Road East, Leicester

A full day to explore some of the major professional issues that face us all in the year ahead. The workshop is to include speakers on :-

National Assessors – Mike Hopley

CPD: The new Society approach – Victoria Burt

Knowledge skills framework – Richard Toogood

*Fees:* £25 to DCP Trent members (including lunch, tea & coffee), £35 to others. There will be a charge for non attendance, without notice, of £25 once a place is reserved. This has been imposed as this is a popular event.

*If you would like to attend, please contact:* Lynn Hartshorn (DCP Subsystems Administrator) or Cathleen Taylor (DCP Subsystems Secretary), Tel: 0116 252 9529 or 0116 252 9548; e-mail: lynhar@bps.org.uk or cattay@bps.org.uk

## Recent Developments in Neurorehabilitation

East Midlands Neuropsychology Group one-day conference

**Monday 23 May 2005**; St Andrew's Hospital, Billing Road, Northampton

The impact of ABI on sexuality ○ Development of a simplified version of the multiple errands test for use in hospital settings ○ Errorless versus errorful learning: what is the most effective learning style in terms of functional skills retraining? ○ Reminiscing: how we help people with amnesia naturally remember and interact ○ Job satisfaction in a neurobehavioural environment ○ Challenges in managing aggressive behaviour within a specialised neurobehavioural service ○ Behaviour disorders and acquired brain injury: an applied behaviour analytic approach ○ Aggressive behaviours observed within a neurobehavioural rehabilitation service: use of the OAS-MNR in audit, outcome and clinical research

To reserve a place please send a cheque for £40 made payable to *St Andrew's Hospital* to Nona Pollard, East Midlands SIG Conference, Kemsley, National Centre for Brain Injury Rehabilitation, St Andrew's Hospital, Billing Road, Northampton NN1 5DG

### References

- Harper, D. (2001). Psychiatric and psychological concepts in understanding psychotic experience. *Clinical Psychology*, 7, 21–27.
- Kirk, S. & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. New York: Aldine.

### Broadmoor interacts

*Tony Black*

Chichester, 2003, £32.50

The title of the book refers to the fact that it covers the period between the Mental Health Acts of 1959 and 1983. There is a deliberate double meaning here, as this was also the period when Broadmoor started to become more open and accountable. Coincidentally this was also a large part of the period when Tony Black was the head of psychology services at Broadmoor. Tony opens the book with a dedication to ‘the staff and patients of Broadmoor hospital, neither of whom are really understood by those outside’. Anyone who has ever worked there knows how true this is.

This is a unique book. It is not really a clinical psychology book, although there are many references to the work that psychologists were doing during this period. What makes it special is that it offers a fascinating insight into the workings of the hospital during this period, written from a unique perspective. Tony was the first and only psychologist ever to be employed in a Special Hospital, and his efforts ensured that psychology became part of the services available to patients detained in there. Indeed he was instrumental in the development of forensic psychology across the UK.

Arguably, anyone with an interest in this area of work should read Tony’s book. It gives a fascinating historical context to this area of the profession. It is a substantial tome, and its content includes everything from humorous personal anecdotes to discussion of significant legal developments. Some may feel that it presents an unrealistically rosy picture of the way the hospital operated, but Tony argues that this was the reality of his own personal experiences. These cannot be discounted or ignored – after all he worked there for 27 years. Few can compete with that.

**Carol Sellars**

### Clinical practice guidelines in mental health: A guide to their use in improving care

*edited by Paula Whitty & Martin Eccles*

Radcliffe, 2004, £24.95

The publication of this book is timely, given the government’s ambitious quality agenda for healthcare in this country. Providing guidelines is one thing, but how to implement them is the most challenging. This book provides some helpful pointers as to how this can be done. It begins by examining what the potential benefits, limitations and harms of clinical practice guidelines are, which is a helpful start, as it puts clients in the central position when considering their implementation. It then goes on to reviewing the process of how guidelines are developed, and the rest of the book gives a flavour of what has been achieved in terms of guideline developments to date.

The specific chapters covered are: health economics and clinical practice guidelines; the legal status of clinical practice guidelines; using clinical practice guidelines; the mental health technology appraisal and clinical guidelines programmes of the National Institute for Clinical Excellence for England and Wales; mental health guidelines development in Scotland; the National Collaborating Centre for Mental Health; using mental health guidelines in the NHS: views from a specialist mental health Trust; and using mental health guidelines in primary care: an example of depression management.

This book has achieved something important and useful. It is readable and accessible, and is appropriate for managers, clinicians and trainees. **Carol Valinejad**

### The person-centred approach to therapeutic change

*Michael McMillan*

Sage, 2004, £15.99

My first observation was that this book was going to be different to what I had expected, with no reference to Prochaska and DiClemente or to Miller and Rollnick. Rather than be deterred, I looked forward to broadening my knowledge of theories regarding therapeutic change. My next scan indi-

cated that I was about to read a considerable amount of information packed into 90 pages. It was obvious that this was not going to be a chatty book on the subject, but an intense critical appraisal and review of key texts and theories. So how was it?

What is very clear is the extent to which Michael McMillan knows the subject. I found the book vacillating between quite intense, research- and theory-based discussions and the more easily readable summaries provided at the beginning and end of chapters. The book seems to lend itself to the psychotherapist wanting an in-depth theoretical discussion regarding the process of change, with examples of earlier chapter titles including: 'The evaluation of experience' and 'The complex nature of self-concept'. McMillan then suggests ways of modifying clinical practice and discusses the necessary and sufficient conditions for facilitating change, addressing issues such as 'To be the self that truly is' and 'Engaging with the complexities of post-modern life'.

In summary, McMillan's book is exactly as described on the cover: 'Focusing explicitly on how change is theorised and facilitated in counselling.' However, I am not too sure that it appealed to me as much as it will to others; perhaps appealing more to those intensely involved in psychotherapy. Nevertheless, I commend Michael McMillan for providing this informed, in-depth account of the area, which will no doubt have an important place within the SAGE Publications' Therapeutic Change series.

**Kirsty R. Lowe**

### **Memory: Special issue on mental imagery in psychopathology (vol. 12, no. 4)**

*edited by Emily A. Holmes & Ann Hackmann*  
Psychology Press, 2004, £35

Distressing imagery and visual memories are a core feature of PTSD and are sometimes reported as having a presence with other psychological difficulties. In his early work, Aaron Beck highlighted that imagery and memories might both provide means of accessing psychological meaning for individuals with a range of difficulties, although in practice CBT has remained a therapy with a mainly verbally based focus. The significance

of mental imagery and memories as cognitive phenomena (at least in the CBT literature) often seems to be neglected. This special issue of the journal *Memory*, aimed at both clinical and experimental psychologists, presents a fairly diverse series of 15 papers investigating imagery and visual memory across a range of psychological perspectives.

Some papers make interesting links between reported imagery in certain so-called conditions (agoraphobia and BPD) and previous contributory experiences. Theoretical models incorporating the possible role of imagery are described in several papers and therapeutic applications are explored in relation to PTSD, depression, social phobia, and a single case study of someone with a diagnosis of psychosis. The final paper attempts to draw themes together in relation to a model of autobiographical memory.

It is a little unfair to make comparisons of a journal issue with a book as they are obviously very different animals. I found that I was not able to read through this issue from cover to cover. I found some of the papers dry and inaccessible, sometimes to the extent that I felt unable to read beyond the abstract. However, I found a number of papers that were of more direct clinical relevance very interesting. Several papers stimulated my thinking sufficiently for me to follow them up through further reading.

Overall, I feel that the editors have succeeded in raising the profile of mental imagery in relation to psychological difficulty and I am sure that this issue will influence further research and clinical developments. Whilst this is not a publication that I would suggest that most clinical psychologists should consider buying, I do think that it is worth seeking out in your local postgraduate library.

**Neil Roberts**

### **Books available for review**

Bellack, A.S., Mueser, K.T., Gingerich, S. & Agresta, J. (2004). *Social skills training for schizophrenia: A step-by-step guide (second edition)*; Guilford Press.

Bracewell, C., Gray, R. & Rai, G.S. (2005). *Essential facts in geriatric medicine*; Radcliffe.

- Charles, R. (2004). *Intuition in psychotherapy and counselling*; Whurr.
- Flouri, E. (2005). *Fathering and child outcomes*; Wiley.
- Gerhardt, S. (2004). *Why love matters: How affection shapes a baby's brain*; Brunner-Routledge.
- Greenwood, L. (Ed.) (2005). *Violent adolescents: Understanding the destructive impulse*; Karnac.
- Hanzak, E.A. (2005). *Eyes without sparkle: A journey through postnatal illness*; Radcliffe.
- Hartley, L. (2004). *Somatic psychology: Body, mind and meaning*; Whurr.
- Japp, J. (2005). *Brain injury and returning to employment: A guide for practitioners*; Jessica Kingsley.
- Martell, C.R., Safren, S.A. & Prince, S.E. (2004). *Cognitive-behavioural therapies with lesbian, gay, and bisexual clients*; Guilford Press.
- McMahon, G. (2005). *No more anxiety: Be your own anxiety coach*; Karnac
- O'Connor, K., Aardema, F. & Pelissier, M-C. (2005). *Beyond reasonable doubt: Reasoning processes in obsessive-compulsive disorder and related disorders*; Wiley.
- Ponsford, J. (Ed.) (2004). *Cognitive and behavioural rehabilitation: From neurobiology to clinical practice*; Guilford Press.
- Raskin, N.J. (2004). *Contributions to client-centred therapy and the person-centred approach*; PCCS Books
- Train, A. (2005). *ADHD: How to deal with very difficult children*; Souvenir Press.
- Tribe, R. & Morrissey, J. (Eds.) (2005). *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists*; Brunner-Routledge.
- Whitman, T.L. (2004). *The development of autism: A self-regulatory perspective*; Jessica Kingsley.
- Whitmore, D. (2004). *Psychosynthesis counselling in action (third edition)*; Sage.
- Yiend, J. (Ed.) (2004). *Cognition, emotion and psychopathology: Theoretical, empirical and clinical directions*; Cambridge University Press.

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

*Time and administrative constraints mean that requests for books which have already been sent for review will not be acknowledged.*

*Thank you for your understanding.*

**1 April 2005**

BPS Psychotherapy and Lesbian & Gay Psychology Sections

## Contemporary Developments in Psychotherapy and Sexuality

A joint day conference chaired by Darren Langridge

**21 May 2005**; Tavistock Centre, 120 Belsize Lane, London NW3

*Speakers*: Chess Denman, Martin Milton, Lyndsey Moon, Ernesto Spinelli

*Cost*: Section members £45, students & unwaged £45, others £75

*Application forms from*: Dr Cassie Cooper, 12 Consiton Court, High Street, Harrow-on-the-Hill, Middlesex HA1 3LP. *For further information contact*:  
D.Langridge@open.ac.uk

# DCP Update

Edited by Simon Gelsthorpe

## The work of the Centre for Outcomes Research and Effectiveness

Steve Pilling (*director of CORE*) and Mike Lucock (*DCP representative on CORE-PPB subcommittee*) describe the work of CORE and its key role in the development of NICE guidance.

CORE is the British Psychological Society's Centre for Outcomes Research and Effectiveness and was established in December 1995. The Centre is based in the Sub-department of Clinical Health Psychology, University College London. Together with the Royal College of Psychiatry (College Research Unit), it also forms the National Collaborating Centre for Mental Health (NCCMH), one of seven collaborating centres, which leads the development of NICE guidelines in mental health.

CORE aims to:

- apply psychological expertise to the promotion of clinical effectiveness;
- evaluate health services and health interventions;
- promote the use of good quality outcome measures, from professional, user and carer perspectives.

The key groups within the BPS that CORE serves are those applied psychologists working in or with an interest in health and social care. These include psychologists working in the clinical, health, counselling, neuro-psychological and forensic areas. Within the BPS, the Professional Practice Board (PPB) is where these groups come together – termed the ‘family of psychology’ – and it forms the link between CORE and the BPS.

There are four main areas of work of CORE:

### 1. *Systematic reviews and guideline development*

- To produce high quality systematic reviews which inform psychological practice and related health care areas and which are readily accessible to

health and social care managers, patients and their carers, and members of the public as well as professional groups.

- To contribute to methodological developments in systematic reviews and clinical practice guidelines.
- To produce clinical practice guidelines, in particular forms that are accessible to professionals, service users and their carers and members of the public.

### 2. *Outcome measurement and monitoring*

- To contribute to the development and implementation of routine outcome monitoring in health services.
- To provide advice to psychological practitioners and others working in the health care field on the appropriate use of routine outcome measures.
- To promote the development and implementation of user and carer focused monitoring methods.

### 3. *Implementation research*

- To extend and deepen the scientific understanding of the psychological processes involved in the implementation of evidence-based practice (EBP) in health services.
- To use a psychological framework to study and support the implementation of EBP.
- To increase the use of psychology theory in implementation research.

### 4. *Health services research*

- To contribute to the evaluation of health service interventions arising from national and local policy initiatives.

- To contribute to the increased involvement of service users and carers in the evaluation of health service interventions.

### NICE guidance

The first NICE guidance from the National Collaborating Centre for Mental Health was published in 2002 on 'Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care'. Guidance was published on eating disorders in February 2004, depression in December 2004 and PTSD in March 2005. Guidelines for the management of anxiety were also published in December 2005 by the National Collaborating Centre for Primary Care and on the management of violence in in-patient settings by National Collaborating Centre for Nursing and Allied Professions in February 2005. Details of these four guidelines are provided in the box. Organisations can contribute to the development of guidelines by registering as stakeholders. Stakeholders have two opportunities to comment on the draft guideline, which is posted on the NICE website during the consultation periods.

There are four versions of each guideline published:

- the full guideline, which contains all of the evidence considered in developing the guideline;
- the NICE guideline, which contains recommendations for the NHS;
- the quick reference guide, which contains the key recommendations of the NICE guideline – it is this version that is printed and sent to the NHS;
- information for the Public, which is written for people without specialist medical knowledge.

NICE guidance currently being developed within the NCCMH are obsessive compulsive disorder, depression in children, bipolar disorder, drug misuse, attention deficit hyperactivity disorder, and antenatal and postnatal mental health.

The NICE guidance is a component of the developmental standards of the Standards for Better Health, which form a key part of

the performance assessment by the Healthcare Commission of all healthcare organisations. As a result, each NHS organisation will be required to have a process for the dissemination, implementation and monitoring of NICE guidance. CORE is also developing a programme of work in support of implementation which takes in clinical guidelines but will in time have a broader focus on clinical effectiveness.

We intend to provide updates of the work of CORE and the NICE guidance within DCP Update. We would welcome views and comments. Please send them to [core@ucl.ac.uk](mailto:core@ucl.ac.uk).

### Links to NICE Guidance

Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

[www.nice.org.uk/pdf/cg009niceguidance.pdf](http://www.nice.org.uk/pdf/cg009niceguidance.pdf)

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care  
[www.nice.org.uk/pdf/CG1NICEguideline.pdf](http://www.nice.org.uk/pdf/CG1NICEguideline.pdf)

Depression: management of depression in primary and secondary care  
[www.nice.org.uk/pdf/CG023NICEguideline.pdf](http://www.nice.org.uk/pdf/CG023NICEguideline.pdf)

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care  
[www.nice.org.uk/pdf/CG022NICEguideline.pdf](http://www.nice.org.uk/pdf/CG022NICEguideline.pdf)

Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments  
[www.nice.org.uk/pdf/cg025niceguideline.pdf](http://www.nice.org.uk/pdf/cg025niceguideline.pdf)

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care  
[www.nice.org.uk/pdf/CG016NICEguideline.pdf](http://www.nice.org.uk/pdf/CG016NICEguideline.pdf)

## Mental Health Minimum Dataset

*Adrian Skinner, the Chair of the DCP Informatics Committee) reports*

For many years the quality of information about the provision of services to people with mental health problems has been very poor. This had a number of undesirable consequences for both provision and planning of these services.

For this reason the Department of Health devised a Mental Health Information Strategy, which resulted in the production of a set of data that would adequately describe the problems suffered by, and services provided to, people with mental health problems – the Mental Health Minimum Dataset (MHMDS). From March 2003 it became mandatory for providers of services to provide these returns to the Department of Health, although these reports are currently not of the full dataset. The Society advised the DoH working group and has expressed its concerns about some data items.

The data items are designed to be extracted from databases, so many uncontroversial items (name, address, date of birth etc.) are harvested from computer systems without the intervention of clinicians. However, there are some items which may cause difficulties for psychologists.

### DCP Rep to Sport & Exercise Division

As you are probably aware, the previous Section of Sport & Exercise Psychology (DSEP) has now officially been formed as a Division. The Division committee is currently considering cross-Divisional representation and has invited DCP to nominate a representative to the DSEP. If you are interested, please contact me.

### DCP Rep to Division of Health Psychology

Karen Ehlert is standing down as DCP rep to the Division of Health Psychology. Anyone interested in taking her place, again please contact me.

**Lesley Dexter**, DCP Coordinator  
Tel: 0116 252 9903

### Current problems

In the current year the item 'ethnic origin' is being performance managed. Although this item is uncontroversial, the method of collection may not be. Many Trusts are reporting that they do not have these data, either because they were not collected at all or because the data were not entered into a database. Keen to 'pass' this test, Trusts are trying to 'refresh' these data by filling these fields in arrears.

Such an approach (of which clinical staff may be unaware as it could be done by clerical staff) poses potential ethical problems, as well as making the data more or less worthless. Ethnicity is the judgment of the client, who has the right to withhold this information.

- Psychologists should not be forced to 'guesstimate' the ethnicity of past or existing clients.
- It is, of course, perfectly acceptable to ask psychologists to collect these data on new clients.

### Potential future problems

There are items in the dataset which cause us particular concern. The two that have attracted our attention thus far, although not yet performance managed, are 'Diagnosis' and 'HONOS scores'.

We are concerned about the Diagnosis field (a code), as many psychologists are not trained in, or do not use, psychiatric diagnosis and will therefore not wish to provide a code. The concern about the HONOS field is that it mandates a particular tool which psychologists may not wish to use for a variety of reasons.

- Psychologists should not be required to provide diagnosis codes if this is not part of their normal practice.
- Psychologists should not be required to use a particular assessment tool.

Our advice, in the event of a psychologist experiencing difficulties at a local level, is that they report this to the DCP via me, and we will attempt to assist and at least amass data about possible abuse.

**adrian.skinner@nhs.net**

## New ways of shaping and delivering psychology services

Graham Turpin, the new Chair of the Division of Clinical Psychology, reports on the joint NIMHE/BPS conference held in Birmingham on 10–11 February 2005.

Applied psychologists and commissioners of psychology services were challenged to think differently about the psychology workforce, if the NHS is ever to meet the increasing user demand to access effective psychological therapies.

This highly successful two-day conference was jointly organised by National Institute for Mental Health in England (NIMHE) and The British Psychological Society (BPS). It was hosted and organised by the Managers Faculty of the Division of Clinical Psychology, together with the Divisions of Counselling, Health and Occupational Psychology, and had three main themes:

- How can psychologists influence strategic health authorities and trusts? – *Angela Carter*;
- Choice and user involvement – *Tina Ball*;
- New ways of working/Career structures for psychologists – *Barry Foley & Graham Turpin*.

The conference began provocatively with a keynote address from Steve Shrubbs (director, NIMHE North East, Yorkshire & Humberside), who addressed the question as to how greater access to psychological therapies could be achieved. He argued that, following the publication of the latest DoH report *Organising and Delivering Psychological Therapies*, no further policy development was required and the next steps must be around implementation. He told the audience that there was now overwhelming evidence for the effectiveness of psychological therapies in treating a wide range of mental health problems. Moreover, psychological therapies should not be considered as optional – they must be seen as a key component of mental health care and services, and should be funded appropriately. He challenged psychologists to consider how their roles might change to enable them to progress this agenda and become responsible for championing psychological approaches to mental health care as being fundamental for the Service.

His call was taken up by several of the groups that broke away to work around the conference themes. The ‘Influencing’ theme identified both strategic and practical ways for psychologists to influence their local management. Strengthening the leadership skills of psychologists was identified as a priority, together with mechanisms to promote greater partnership working between local psychologists and SHAs and regional NIMHE offices. The ‘Working with service users’ theme looked at two practical examples of where psychologists and service users could work effectively together – the choice agenda and how to increase access to psychological therapies. Bill Davidson from Impact Research set the tone for the theme by emphasising the benefits of choice in empowering users to recover and move on from mental health problems. Establishing better communication between psychology and users was also identified as a priority and the establishment by the BPS of a Service User Liaison Committee would facilitate these developments.

The third theme considered career structures for psychologists and attempted to review all stages of a psychologist’s career, ranging from assistant to consultant. Mike Shooter, President, Royal College of Psychiatrists provided an overview of the New Ways of Working initiative that has focused on psychiatry. This prompted many to consider a similar exercise looking at psychology and how roles and responsibilities might be redefined to allow psychologists to contribute to making mental health services more psychological in nature. A tension within the theme was the expectation that psychologists had to deliver as psychological therapists in widening access to users, but at the same time there was indirect work to be achieved within the Service around consulting into multidisciplinary teams, providing multi-professional supervision, clinical leadership, service redesign, evaluation etc.

The conference was brought to a close by Roslyn Hope, director of workforce, NIMHE

who summarised the actions to be taken following the conference. A first priority was to develop service models to support increased access to psychological therapies. A second priority was to take forward further work on New Ways of Working and Career Frameworks for Psychologists, particularly focusing on clinical leadership. Further detailed notes of the conference will be posted on the BPS and NIMHE websites.

Division of Neuropsychology  
Post-Qualification Training Day

**Possibilities for psychological  
therapies following acquired  
brain injury: Fact, fiction and  
formulation**

**Friday 27 May 2005;**  
The Resource Centre, 256 Holloway  
Road, London N7

*Topics include:* ○ Psychological formulation and ABI (Dr Fergus Gracy & Dr Giles Yeates); ○ Neurobehavioural formulation (Dr Nick Alderman); ○ CBT formulation (Dr Fergus Gracey); ○ Gestalt formulation (Dr David Quinn); ○ Neuro-psychanalysis formulation (Prof. Mark Solms); ○ Systemic formulation (Dr Giles Yeates).

*Further information from:*

Prof. Michael Oddy  
Brain Injury Rehabilitation Trust  
Burgess Hill  
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Tel: 01444 237287  
Fax: 01444 244978;  
e-mail: birt@disabilities-trust.org.uk

## DCP Chair's column

### What have the Romans ever done for clinical psychology?

Well, just another 361 days to go as Chair and 11 more columns for *Clinical Psychology*. In the interests of getting across the DCP's message to its members, I have rather rashly agreed to write a monthly column on the invitation of Jonathan Calder, the DCP's Communication Officer but what should I say?

Despite a lot of thought, I finally came up with a rather uncreative approach of sharing my diary with DCP members as a means of communicating what's on the DCP agenda nationally and how the Chair is involved. At this point it's worth emphasising that the DCP is much more than its Chair, and many other office holders from the Full and Executive committees, DCP Faculties and Special Interest Groups, together with BPS and DCP staff, are busy promoting the work of the Division throughout England and the devolved nations.

Well here goes, March has been a busy and productive month. Of particular importance to practitioners in the NHS, was the agreement and final publication of the Agenda for Change job profiles on the DoH website (<http://tinyurl.com/6o297>) and the introduction of Band 9 for some psychologists. This is a successful conclusion to a very productive collaboration between AMICUS and the DCP. Our thanks especially go to Dorothy Fielding, Jake Lyne and Patrick Smuts for negotiating this so successfully. The efforts continue, however, around the Knowledge and Skills Framework and indeed a date for your diaries is 24 June when the DCP is holding a KSF conference (see the DCP website for further details).

The DCP has also been in discussions with the Department of Health and the National Institute for Mental Health England (NIMHE) following the highly successful collaborative conference held in February and organised by the Managers' Faculty (see my reort elsewhere in CP Update). We hope to post the full notes of this meeting on the DCP website in the near future. NIMHE are

also pursuing the idea of a New Ways of Working project which would review the roles and responsibilities of psychologists working at all levels within health and social care – watch this space.

Anyway back to the diary, in March attended five full days meetings in London including a DCP Executive meeting, the Standing Committee for Psychologists in Health and Social Care, Group of Trainers and, perhaps the most interesting, an ‘expert professional symposium’ organised by the Social Exclusion Unit of the Office of the Deputy Prime Minister ([www.socialexclusion.gov.uk](http://www.socialexclusion.gov.uk)). This was an interesting day where different professions were invited to state what they could contribute to this fundamentally important agenda: psychologists, I am pleased to say were the best represented group, largely due to Fabian Davies, efforts in inviting members of the Psychosocial Rehabilitation SIG.

Other meetings attended included a day in York looking at the Associate Psychologist proposals and the setting up of a pilot scheme in the North of England. We also discussed the Modernisation Agency’s and NIMHE’s consultation on associates, and the

50 or so responses that this stimulated. It is hoped that a report jointly authored by the Society and NIMHE summarising the responses and the issues will be produced sometime within the summer. Talking of consultations, one minor task is to coordinate the DCP’s response to the DoH’s consultation on HPC (<http://tinyurl.com/6cbb7>) – please send in your views to the DCP and the Society.

April finished with attending the BPS Quinquennial Conference in Manchester which was again a DCP success due to Peter Kinderman’s ground breaking inaugural meeting on Psychology & Human Rights, an excellent programme convened by the DCP conference committee (Sue Grey and Steve Jones) and a presentation from Rosie Winterton, the minister of state for health. But more about the conference next time...

And then there are the teleconferences, correspondence, phone calls.

**Graham Turpin**

DCP Chair (1430/433/26)

*There is a prize for anyone who can exactly decrypt the numbers each month.*

## DCP SCOTLAND

# Seeing Trouble Coming: Anticipating difficulties in clinical supervision

**David Green**

Clinical Director, D Clin Psychology programme, University of Leeds

**Friday 13 May:** Highland Hospice, Inverness

*Application forms from:* Dr. C. J. Dobson, Area Clinical Psychology Service, New Craigs, 6–16 Leachkin Road, Inverness IV3 8NP; Tel: 01463 704683; e-mail: [caroline.dobson@hpct.scot.nhs.uk](mailto:caroline.dobson@hpct.scot.nhs.uk)

### March 25

Nigel a bit miserable tonight. Didn't appreciate my suggestion that he reads *Cheer Up, You Only Think The End is Nigh*. N pointed out that the end is 'always bloody nigh nowadays – either thru global warming, terror alerts or Avian Flu'. Made a mental note to check symptoms of AF – been feeling a bit wheezy recently.

### March 30

Therapy group interesting this morning. Loads of talk about the therapies everyone has had. Two people in group have been Rolfed – nothing to do with TV Aussie painter apparently. Said it was weird but no weirder than Cognitive Analytic Therapy – you have to spend hours writing out all your traps. Alison sprang to mind for some reason. Two of us have seen clinical psychologists. Tony said his was very kind but didn't seem to realise that keeping a thought diary was not top of his agenda. Millie saw nice psychiatrist who recommended the group and said that he had found reading novels really helpful when he had been depressed. Must ask her which ones.

### March 30 (later)

Alison not as interested in novels as I'd have thought – book group has already compared novels with self-help books. June says that if you are really depressed reading anything at all is an achievement. Pair of them getting me down. Off to call centre this p.m.

### March 30 (very late)

New contract at call centre for directory enquiries stuff. Chap from somewhere snobby wanted to know number of The Ivy. Had to remember to say, 'Shall I put you straight through?' *Everyone* says, 'No.' When will contractors realise the public isn't that gullible?

Call from woman saying she wanted to travel to Barnsley. Tempted to ask, 'Why?' – then checked list on desk and, sure enough, we do travel info too. Had to ask bus or train then went online for details.

### April 2

Graham didn't know that 118 118 will tell you anything you need to know. Wondered about phoning in for relationship advice. Things a

## Self-help



bit sticky right now. Recommended group therapy – no one seems to have learnt much from facilitators but we have started meeting for coffee and Millie and Tony are hitting it off really nicely.

### April 6

Group talking about different therapies again. Apparently my CP was a bit unusual in being so versatile – most of them do cognitive therapy. Tony reckons it's 'cos they are bright and think that thinking about changing things will make a difference. Millie says there is some kind of battle between counsellors, psychotherapists, clin psychs and counselling psychs – read it in report about BPS conference in Manchester last week.

### April 8

Pub. Told Graham about therapy in-fighting. Says it's no different from garages claiming to be the best ones to fix a particular brand of car – in the end your go wherever is closer and, better still, on the way to the shops. Nigel says he goes to whoever will give him a courtesy car. Hadn't noticed anyone offering a car at the group but the coffee's OK. Both of them more fired up by all the stuff in the news about Charles and Camilla. N says he can't believe anyone cares. G says election will be worse – he doesn't know *anyone* talking about it but the papers are full of political sloganeering.

### April 14

Wow! A says she has organised postal votes and we'll be away for the election. Just us, Tim, twins and several packets of condoms. Several! The end isn't quite nigh after all.

*Felix Q.*