



Doctorate in Clinical Psychology

Course Newsletter

Winter 2015

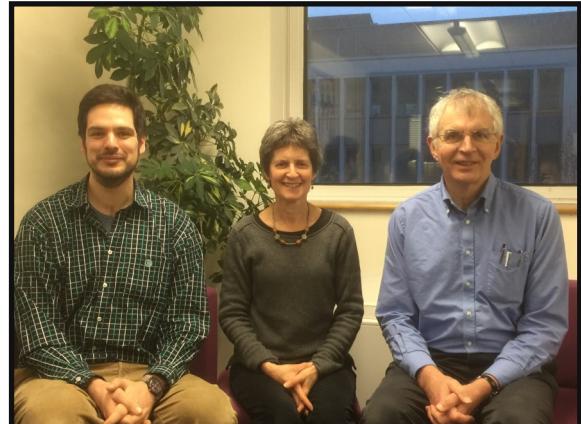
Welcome to the ninth edition of the UCL Doctorate in Clinical Psychology Course Newsletter and Happy New Year to all our supervisors and colleagues in the region. In this packed edition we hear from Joint Course Director, Tony Roth on two recent course developments in response to changes in BPS accreditation criteria (Embedding Practice Based Evidence into Doctoral training and Structured Observation). We welcome new staff member, Dr Rachel Whatmough (nee Brindley) to the UCL clinical tutor team and provide information on the Independent Personal Advisor scheme available to all trainees across the three North Thames courses. As well as hearing about some exciting developments on the course, there are also details on our forthcoming Spring conference and supervisors workshops to which all supervisors are invited to register.

Wishing you all a happy 2015
Jarrod Cabourne (Clinical Tutor)

A message from Will Mandy, Research Director.

This year I have taken over from Nancy Pistrang and Chris Barker as Research Director on the UCL course. Nancy and Chris are reducing their hours - not retiring - but nevertheless this seems like a good opportunity to reflect on the enormous contribution they have made in their two decades as joint Research Directors at UCL.

Their influence to the UCL course – and to our profession more generally -has been immense, and entirely beneficial. During their tenure they facilitated the launching of hundreds of careers in clinical psychology, supporting the DClinPsy research of over 20 generations of trainees. I think it is telling that both Chris and Nancy conduct research into processes of helping – they are exceptionally skilled helpers of trainees and colleagues. Many of you reading this will have your own memories of being helped by Nancy and Chris – and will have benefitted from their combination of intellectual rigour and unmistakeable kindness. We are all very glad that they continue to play a pivotal role on the UCL clinical psychology course. I am keen to continue to foster research collaborations between our students and clinical supervisors in the region. If you have any ideas for a trainee research project, please do check out the website for more information (http://www.ucl.ac.uk/dclinpsy/trainee-research/Research_documents/res_external_sups_guide) or get in touch with me by email on w.mandy@ucl.ac.uk.



Community Psychology Lunchtime Seminars

Melanie Claxton, Anna Clarke, Lucy Gore and Sarah Bargiela

The community psychology trainee-led lunchtime seminars were initiated by a former UCL trainee, Jed Shamel, who had made links with a number of psychologists in the field. As four second-year trainees (at that time), with an interest in critical and community psychology, we had heard about Jed's initiative through a conversation had between Sarah and Jed over a coffee. Jed shared his experiences of organising the lunchtime lectures at UCL, encouraging and urging their continuation. With resounding support from the course, we came together to discuss our interest in supplementing the training curriculum with perspectives on how psychology might be practised in ways which explicitly promote social justice. We invited a list of inspiring and critical-thinking individuals who also shared how community psychology principles might be translated into everyday practice. The speakers included Clinical Psychologists Jim Orford, a figurehead in calling for change in the gambling industry, and Angela Byrne reflecting on third sector work with HIV positive women, as well as an introduction to critical psychiatry from Psychiatrist Joanna Moncrieff. Trainees from our cohort were invited to attend during their lunchtime, and we were pleasantly surprised to find the lecture room was full for almost every one of the five talks.



From Left: Melanie Claxton, Sarah Bargiela, Lucy Gore, Anna Clarke

Impacted directly on people's practice on current placements, and influenced their choice of future placements - for example, a number of trainees who had not considered this previously asked for community psychology placements in the final year):

"[The seminars] help me keep one eye on any issues that arise with a patient which apply to more than just his or her individual well-being, such as stigma and lack of public education in HIV or social inequality in Hackney, and to think about we might formulate social goals (patient aims to speak out about stigma) as well as personal goals (patient hopes to reconnect with friends) for therapy."

As third year beckoned, we had discussions on how the community psychology talks could continue, and presented the idea to the first and second year trainees. A group of second years have now succeeded our role, and have invited a number of community psychology speakers to engage with their cohort. The four of us now plan to participate in the second year teaching session on community psychology in May 2015, with a view to facilitating some workshops that can hopefully embody and inspire the spirit of community psychology, to be put into practice on placement, and in later qualified life.

The feedback we received from our cohort through a poll at the end of the year was positive and encouraging. There was evidence that the seminars had:

Introduced people to new ideas and broadened their view of what clinical psychologists could do:

"Before I started the course I had not heard about community psychology work at all. I found it very refreshing to hear from psychologists about the different ways they have gone about tackling psychological and social problems in non-individualised way. Hearing about the approach in action allowed me to see how creative psychology could be."

Cultural Competence teaching at UCL, Kat Alcock, Senior Clinical Tutor & Henry Clements, Clinical Tutor

UCL are committed not just to increasing the diversity of the profession, but also to adapting our teaching in order to fully benefit from and respond to changes in our trainee cohorts. In line with our Widening Access to Clinical Psychology agenda, we have adapted the way in which issues relating to difference and diversity are addressed within training as a whole, in collaboration with UCL trainees, supervisors and service users from the region.

The “Difference and Diversity” module has been renamed “Cultural Competence”, and has been more clearly grounded in relevant theory and research. The module now consists of two broad introductory sessions, in which trainees are introduced to key frameworks and develop their own cultural biographies. These introductory sessions are followed by a series of “spotlight” sessions focusing on particular topics, including sexuality, gender, religion and spirituality, social inequalities and health, community psychology and engaging clients from BME backgrounds. Most spotlight sessions are preceded by trainee self-study, set by lecturers, and trainees are encouraged to bring their own clinical material to teaching sessions.

There is protected space in reflective practice seminars for focusing on issues around cultural competence, and clinical seminar facilitators are now provided with explicit guidance to encourage reflection about the interaction between trainee and client values. This guidance is part of a broader “Cultural Competence Toolkit”, developed in collaboration with UCL trainees. This toolkit is intended to be used across all aspects of training, including clinical and supervision sessions. As part of the cultural competence module, trainees have also developed an evolving online resource document for working in a culturally competent manner, which is available to them on UCL Moodle.

New Staff Members

Rachel Whatmough (nee Brindley) – Clinical Tutor

Rachel joined the Clinical Tutor team in August and is based in the department three days a week. Rachel trained at the Institute of Psychiatry and specialises in the field of physical health. Post qualification, she has worked within the field of chronic pain (St Thomas' Hospital), chronic lung conditions (St Marys' Hospital), and oncology (Maggie's Cancer Care). Rachel has a strong interest in mindfulness and completed her teacher training through Bangor University in February 2014. Together with colleagues, she hopes to develop the mindfulness opportunities available to trainees during their training.



Developing the Independent Personal Advisor Scheme

Jarrod Cabourne, Clinical Tutor

The role of the Independent Personal Advisor (IPA)

The IPA system is a long-standing support structure for trainees across the three years of training. It is generally agreed that all trainees benefit from an opportunity to discuss and review their professional development and experiences during training with someone who is independent of the course. The potential role of the advisor also includes the provision of personal support as well as acting as an advocate for the trainee if disputes arise out of academic and clinical aspects of the course. It is hoped that the advisor will build up a trusting relationship with their trainee and develop knowledge and understanding of the trainee's background, ongoing experience of the course and aspirations for the future. As a course we provide all trainees studying at one of the three North Thames courses (UCL, University of East London and Royal Holloway) the opportunity to access an IPA.

The IPA process

If a trainee wishes to make use of the IPA scheme, they are invited to contact an advisor of their choice from the register of clinical psychologists in the region who have signed up to the scheme. As this is now an opt-in system and trainee needs vary, it may be that some advisors are not contacted each year. In order to assist trainees making their choice of who to contact, we aim to keep a brief summary of each IPA's area of interest on record. If an IPA agrees to meet with the trainee, they will usually continue to meet throughout the course of training however it is for them to decide the frequency of meetings.

IPA Policy

To be eligible for the scheme, advisors must have two years post qualification clinical experience.

Personal advisors are also bound by the HCPC and BPS Code of ethics and conduct.

Contact between the trainee and advisor is confidential, but with reference to previous codes of ethics and conduct, there may be circumstances in which confidentiality would have to be breached.

The personal advisor will not act as a clinical supervisor to the trainee at any time. If a trainee or advisor considers that the pairing is unsatisfactory they may terminate the pairing at any time.

The next step...

As clinicians often move posts, I am currently updating the IPA register to ensure that trainees across the three courses have access to the most up to date contact information of clinicians willing to be a part of the scheme. If you were previously part of the scheme, you should have received an email from me recently. If you did not get this e-mail and would like to continue to act as an IPA, or indeed you have never been part of the scheme before but would be interested in registering, please contact me on jarrod.cabourne@ucl.ac.uk. We also aim to provide support for trainees who are parents and/or carers, LGBT trainees and for black and ethnic minority trainees. If you feel you have a particular interest and/or competences to act as an advisor in any of these additional schemes, this would be welcomed. I would be happy to answer any questions and look forward to registering you as an IPA.

LONDON's GLOBAL UNIVERSITY

Doctoral Course in Clinical Psychology

Gower Street,

London

WC1E 6BT



UCL

Spring Conference

The experience and psychological consequences of detention in secure environments,

Vyv Huddy, Lecturer



The UCL DClinPsy March conference concerns the experience and psychological consequences of detention in secure environments such as prisons, young offender institutions or immigration detention centres. Populations detained in these settings are likely to have experienced stressful life events that can either increase their risk of developing mental illnesses or exacerbate existing difficulties. The secure environment presents significant obstacles to the implementation of psychological therapies that aim to bring about recovery. Furthermore, the experience of the deprivation and separation is also a consideration for therapists working with people during resettlement after detention and beyond. This conference will aim to increase awareness of research in this socially excluded group in general, the effects of imprisonment and best practice for working with this population.

Further details on the conference, including speakers and location will be distributed shortly. For further information or to register your interest, please e-mail our academic administrator Leah Markwick (l.markwick@ucl.ac.uk).

Supervisor Workshops 2015

Two-day Workshop for New Supervisors

Thursday 11th & Friday 12th June 2015 / 10.00am to 4.30pm

Host: UEL, Tel: 020 8223 4501, E-mail: clinpsyworkshops@uel.ac.uk

Advanced Supervisor Workshops

Thursday 5th February 2015 / 10.00am to 4.30pm

Host: RHUL, Bedford Square, 2 Gower Street, WC1E 6DP, Tel: 01784 443851,
E-mail: clinpsyworkshops@rhul.ac.uk

Friday 19th June 2015 / 10.00am to 4.30pm

Host: UCL, Tel: 020 7679 8231, Fax: 020 7916 1989, E-mail: placements-admin@psychol.ucl.ac.uk

Developing Service Related Research

Friday 28th November 2014 / 1.30pm to 4.30pm

Host: RHUL, Bedford Square, 2 Gower Street, WC1E 6DP, Tel: 01784 443851,
E-mail: clinpsyworkshops@rhul.ac.uk

Leadership in Clinical Psychology

Friday 20th March 2015 / 10.00am to 5.00pm

Host: RHUL, Bedford Square, 2 Gower Street, WC1E 6DP, Tel: 01784 443851,
E-mail: clinpsyworkshops@rhul.ac.uk

Complex Case Supervision

Thursday 21st May 2015 (date tbc) / 10.00am to 4.30pm

Host: UCL, Tel: 020 7679 8231, Fax: 020 7916 1989, E-mail: placements-admin@psychol.ucl.ac.uk

Neuropsychological Assessment

Friday 8th May 2015 / 10.00 am to 4.30pm

Host: UEL, Tel: 020 8223 4174, E-mail: clinpsyworkshops@uel.ac.uk

Systemic Supervision

Friday 15th May 2015 /10.00am to 4.30 pm

Host: RHUL, Bedford Square, 2 Gower Street, WC1E 6DP, Tel: 01784 443851,
E-mail: clinpsyworshops@rhul.ac.uk

New BPS Accreditation criteria

What do they mean for training? - Part II

In the last edition of the newsletter, we spoke about recent changes in BPS accreditation criteria and what this means for training. You can find these on our website at www.ucl.ac.uk/dclinpsy/handbook-publication/appendix4. In this edition we focus in more detail on two of these developments; Practice based evidence in clinical practice and evidencing of skills on placement through structured observation.

Embedding Practice Based Evidence into Doctoral training Tony Roth (Joint Course Director)

In recent years evidence-based practice has become part of the landscape, and though there is plenty of scope for debate about what this means, and how far it should shape the services we offer, it is an important determinant of policy. However, there is a risk of seeing evidence-based practice as a one-way process, because implementation of an evidence-based approach does not guarantee that it will be effective. The only way to determine this is for practitioners to embrace the idea of practice based evidence (PBE) – a systematic approach to examining their own outcomes. It could be argued that without this, practice is not truly evidence-based.

The 2013 BPS Accreditation criteria make several reference to PBE, and indicate that as a profession we should adopt a “...critical evaluative stance ... which includes utilising an outcomes framework, informed by well-being and recovery principles, as well as the values and goals of the service user”. In relation to training, PBE is defined as a “critical and reflective evaluation of processes, outcomes, progress and needs”.

What this means is collecting systematic evidence of progress. The UCL programme is keen that this is a meaningful exercise, for supervisors and trainees, and especially for service users, and one to which all parties can contribute their ideas. So what do we have in mind?

Firstly, we think that all trainees should be moving towards routinely and systematically monitoring progress, not just at the start and end of an intervention, but throughout. How this is done may vary considerably depending on the setting, the client group and the type of intervention. The important thing (and indeed an important skill) is to identify ways of measuring that are relevant and meaningful. Sometimes – often in fact – this will mean using standardised measures, but in many cases it makes a lot of sense to use idiographic measures that can be tailored directly to capture the areas of change that service users are keen to address. And of course, measures take many forms: for example, charts monitoring changes in behaviour (such as a child’s sleeping patterns) are already a standard procedure in many settings.

Secondly, we want trainees to collate these outcome measures into a portfolio, and use this to as the basis for reflecting on the impacts of their work. The critical word here is ‘reflect’ – not everyone improves or responds, not everyone is suitable for an intervention, and an important part of training should be a capacity to think about what went well, and what didn’t go so well, and to do so in a way that enhances future practice.

Thirdly, we are keen that PBE is a collaboration between service user and trainee. There is a real risk that measures are something that is imposed on service users, something we wish to avoid. So trainees are encouraged to make sure that the purpose of a measure is fully explained to clients, that they know what their pattern of scores means, and measures are used as a springboard for further discussion. Engaging the service user with measures is an important skill – helping them to be curious about their progress, and to think about whether and how an intervention is working for them. This should be empowering for them, because it ensures that there is a channel for explicitly discussing these issues.

Fourthly, measures need to be included in supervision – potentially they are a really helpful adjunct to discussion. Much of the time client progression – or failure to progress – is reasonably clear, but there is good research evidence that indicates that clinical judgment alone can lead us to over- or under-estimate how well an intervention is going. Adding some sort of systematic measure should help supervisors and trainees focus on the cases where progress is slow, or where service users look to be deteriorating – thinking hard about the reasons for a lack of progress can be enormously helpful, and research suggests that using measures to point towards such cases makes it much more likely that they will be identified.

This is quite an ambitious set of aims, and for now the focus of our activity is on the trainees who started with us in 2014; for the second and third year trainees our aims are more modest. The tutor team has been in touch with supervisors to discuss PBE, and we know that there has been a mixed reception to this idea. We are keen to maintain a dialogue about how best PBE is introduced, and what it should mean in practice for each placement setting. The worse thing we could do is to be seen as imposing something that felt inimical to local providers, and so we would be keen to hear responses to this initiative. One point of discussion would be the Mid-Placement Review, but I would be happy to be emailed (a.roth@ucl.ac.uk) or phoned (020 7679 5925) if there queries or comments about our proposals.

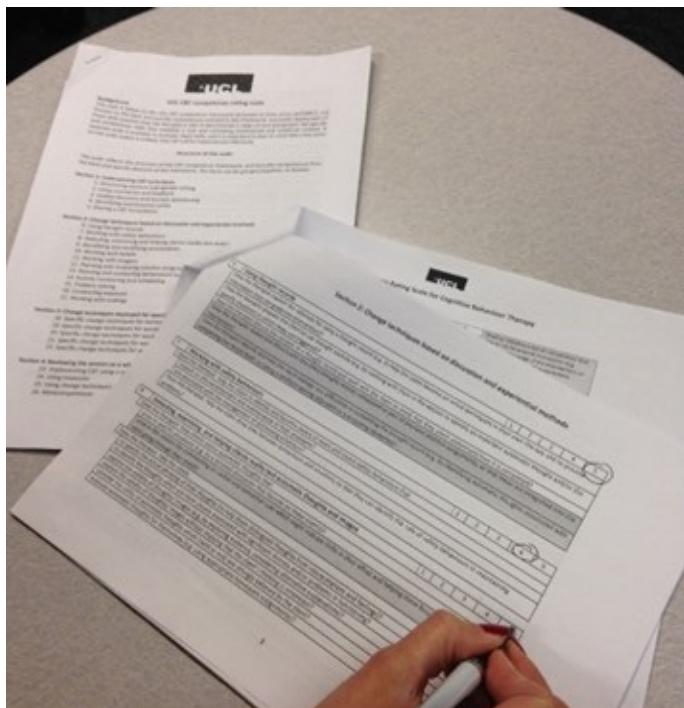
Structured Observation

A Guide for Supervisors and Trainees

Tony Roth (Joint Course Director)

One of the most powerful tools for learning clinical skills is to be observed and to receive feedback on what we did well, and also on what went less well. Over the years more and more supervisors include observation as a routine part of the supervision process, and for good reason – as well as its value as a learning tool, it also means that supervisors have a better sense of the accuracy of their trainee's self-report.

Observation is only as useful as the feedback that follows from it; we know from research that specific, behavioural feedback is much more effective than global comments that speak to generalities rather than to the specific case. This is well-documented across different therapy modalities – it applies to CBT as much as to psychodynamic approaches, for example. As such, 'structured' observation is increasingly encouraged – and in fact programmes are being mandated to move towards this by the 2013 BPS Accreditation criteria.



To help supervisors structure their observations, UCL has developed two 'tools'; one for 'Generic Therapeutic Competences' (which covers the basic skills seen in any therapeutic modality), the focuses on CBT competences. Both are based on the competence frameworks for psychological interventions developed by UCL (all accessible at www.ucl.ac.uk/CORE/).

The scales are best used for formative feedback – in other words, describing the strengths of an intervention, as well as the areas needing development. The scales lend themselves to this because they contain a lot of behavioural descriptors for each area of competence, and so act to remind supervisors – and trainees – of the features that should be being exemplified.

The scales have been piloted over the past year with UCL trainees and their supervisors, and have been adapted in the light of their feedback. We are conducting formal research to check on their inter-Rater reliability, and cross-checking their performance against the Cognitive Therapy rating Scale. And it is likely that we develop scales for psychodynamic therapy and systemic therapy shortly.

The scales (and background documents and scoring sheets) are available to download at <http://www.ucl.ac.uk/dclinpsy/clinicalplacement> (in the tab marked 'Scales for structured observation').

To provide feedback on the scales, please discuss this at the MPR or contact a.roth@ucl.ac.uk

Research Updates

Compassion in Virtual Reality, Caroline Falconer, Postdoctoral Research

A team of research psychologists and computer scientists from University College London have designed a method to improve people's compassion to themselves, by creating a unique self-to-self situation using avatars and computer gaming technology. Virtual reality has previously been used to treat psychological disorders including phobias and post-traumatic stress disorder but this ongoing research focuses on a new application for promoting emotional well-being.

Participants in the research are all trained to express compassion towards a distressed virtual child while "in" their adult virtual body. As participants talk to the crying virtual child, it appears to listen and respond positively to their compassion. In the second part of the session participants re-experience their compassionate response from the perspective of the child. This perspective shift creates a unique self-to-self situation whereby the participant can, in essence, experience compassion from themselves. The innovative approach reduced self-criticism and increased self-compassion and feelings of contentment.

The research team, in collaboration with Camden and Islington IAPT services, are now conducting an in depth longitudinal study with a depressed clinical sample to investigate the longevity of effects. This research branch is unique to UCL and has trainee clinical psychologists involved in its development. The ultimate goal is to develop therapeutic interventions for treatment resistant clinical populations where excessive self-criticism, shame and guilt play a prominent role in their maintenance and relapse."

Course web address: <http://www.ucl.ac.uk/dclinpsy/>

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