

# Editorial

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### Healthcare advice from BACP

BACP and the BACP Healthcare Team welcome your queries on healthcare counselling and psychotherapy related issues. To get in touch, please email us at [healthcare@bacp.co.uk](mailto:healthcare@bacp.co.uk) or telephone 01455 883300 (ext 331) to leave a message for a member of the team. Please remember to quote your BACP membership number.

Asking clients to complete outcome measures is an everyday occurrence for most practitioners working in healthcare. As the requirement to provide evidence of therapy's quality, effectiveness and efficiency grows, collecting outcome measures is increasingly a service requirement. When I began as a practitioner, I asked clients to complete measures at the beginning, middle and end of therapy; now it is every session, and, on top of the minimum requirements, I can also choose from a range of disorder-specific questionnaires.

It is increasingly necessary to use outcome measures, so how can we make them work for us and, more importantly, for our clients? Nic Streatfield's article asks – *how do you use yours?* He takes us through the three broad categories we can fall into – *ignore* (pretend they don't exist and don't use them), *append* (tag them on to the beginning or end of the session) or *integrate* (use them actively and collaboratively to aid therapy). Nic puts forward a persuasive case to us all to try the latter, showing us how measures can enhance the work we do and sharing his own personal journey from being someone who gave in nameless statistics to the administrator to someone who uses measures for, as he puts it, 'the dialogical possibilities they contain' If, spurred on by Nic's article, you want to breathe life into your testing procedures, and ensure you keep within recommended benchmarks and competencies, Tina Thomas outlines how.

Elsewhere on the subject, Alex Mitchell's research group asks whether clinical skills in diagnosis are adequate without screening questionnaires; outcome measures find a supporter in GP John Hague; and our brief guide takes you through some of the most widely used outcome measures for depression and anxiety.

On a service-related, but different subject, Brian Rock and Helen Brindley examine the impact of record-keeping on the therapeutic relationship, particularly in light of the increasing use of electronic patient records (EPRs). Adding a consideration of the issues from a psychoanalytic perspective, this thought-provoking article recounts some of the clinical dilemmas that arise in the context of the continuing implementation of systems.

Collecting data is integral to continued commissioning of services, and non-IAPT counselling and psychotherapy services are increasingly seeing the value in proving their worth to commissioners by proving their effectiveness. Southwark Counselling and Psychotherapy Services (PCCPS) is a superb example of good practice in this area. As Peter Thomas outlines, by valuing the practitioners, collecting outcome data, and celebrating their work publicly, the PCCPS has secured its place in psychological services in Southwark.

Away from service issues, Maxine Aston provides valuable guidance in approaching work with people with Asperger syndrome. Depression, as Maxine writes, has a high incidence in this section of the population, so it's likely that many of you will have seen people with AS. In a further anecdote to a service-based issue, Ewan Davidson takes us on a personal journey through the patch where he lives and works, giving words to experiences which will resonate with many of us.

As ever, we welcome contributions from readers, whether through correspondence, or ideas for articles. Perhaps you have a personal practitioner's perspective to share? Or are engaged in work or study-based research which could be of interest to others? Please do get in touch with me at the email below if you'd like to submit a letter or idea.

Sarah Hovington  
[hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)

# News

## Mental health stigma hits relationships

A partner is four times more likely to leave because of a mental health condition like depression than because of a physical disability. This is one of the main findings of research carried out for Time to Change ([www.time-to-change.org.uk](http://www.time-to-change.org.uk)), the nationwide campaign led by Mental Health Media, Mind and Rethink, to end the stigma faced by people with mental health problems.

The research, which examined current attitudes to mental health problems, found the stigma, which is often identified in the workplace, extends to close relationships. Attitudes to more severe mental illnesses such as schizophrenia are even worse; the survey asked people about issues that would make them break off a romantic relationship and found that 20 per cent of British women wouldn't stay with someone if they were diagnosed with schizophrenia, yet only one per cent would break up with someone who became disabled and needed to use a wheelchair. However, the picture wasn't all bad, with many saying they wouldn't dream of leaving a partner with a mental health condition.

Source: Press Association/  
Aware Defeat Depression



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## Veteran support helpline launched

Veterans with mental health problems are receiving targeted support via the Combat Stress Support Helpline, a one-year pilot service delivered by Rethink and funded by the Government.

The 24-hour freephone helpline – 0800 138 1619 – aims to help veterans and their families access expert advice from people trained and experienced in dealing with ex-Service men and women and their often complex mental health needs. The helpline aims to provide round-the-clock support, as well as helping callers to access mental health services in their local area, and providing assistance in accessing further advice on other social problems affecting veterans, including housing and employment advice. A text and email service will be added later this year.

Source: Rethink

## OCD trials underway

Two trials aimed at improving the treatment of children and adolescents with obsessive-compulsive disorder (OCD) have been launched by South London and Maudsley NHS Foundation Trust (SLaM). In the first trial, the effectiveness of cognitive behavioural therapy (CBT) carried out over the telephone is being compared to face-to-face treatment. The second trial is investigating whether the efficiency of CBT is enhanced when combined with a drug called D-cycloserine; the drug has previously been found to enhance CBT outcomes by speeding up the process in which people become less afraid of their feared stimulus.

Source: Mental Health Today

## Antidepressants may not improve all symptoms of depression

Even people who show a clear treatment response with antidepressant medications continue to experience symptoms like insomnia, sadness and decreased concentration, researchers at UT Southwestern Medical Center in the US have found.

The researchers analysed data from the *Sequenced treatment alternatives to relieve depression*, or *STAR\*D study*, the largest ever study on the treatment of major depression disorder which took six years to complete and included more than 4,000 patients with major depressive disorder.

The findings of the analysis suggest that widely used antidepressants, while working overall, miss certain symptoms. The researchers tracked a range of symptoms at the start of the trial and at the end of the antidepressant treatment course, including sadness, suicidal thoughts, and changes in sleep patterns, appetite/weight, concentration, outlook and energy/fatigue.

All responders reported between three to 13 residual depressive symptoms, and 75 per cent of participants reported five residual symptoms or more. Some of their symptoms included insomnia that occurs in the middle of the night (nearly 79 per cent), sadness (nearly 71 per cent), and decreased concentration and decision-making skills (nearly 70 per cent). Thoughts of suicide rarely persisted or emerged during treatment, providing, say the researchers, evidence to counter fears that antidepressant medications increase thoughts of suicide. The next step, the authors conclude, will be to develop more targeted antidepressant therapies to decrease depressive symptoms.

Source: ScienceDaily



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## Find out more about research

If you are interested in finding out more about research, BACP's academic journal *Counselling and Psychotherapy Research (CPR)* can be a valuable resource. Along with its quarterly publication of the latest research, it hosts a web portal at <http://www.cprjournal.com/>. This contains information and resources about how to conduct research, together with selected abstracts from past journal issues. BACP members can access the full journal articles from all past *CPR* publications in pdf format, via the BACP home page. Just log in and select 'CPR online' and this takes you to the informaworld site which manages the *CPR* journal publication.

For those who would like to know what is happening in research, but find it difficult to keep up to date with the full articles in the journal, there is a user-friendly e-alert of upcoming articles which you can subscribe to. A summary of articles appearing in the forthcoming issue is sent out quarterly to all those who subscribe. To receive your copy of the e-alert (also available to non-BACP members), go to: <http://www.bacp.co.uk/forms/rNewsletter.php>

## 2011 BACP awards

BACP has announced details of its awards scheme for this year and is now welcoming applications from members wishing to inform the wider professional community about the excellent and innovative work they have achieved within their sectors.

Previous winners of the BACP awards have received significant recognition within the public arena as well as the professional context. BACP hopes that more of its members – whether they are individual practitioners, researchers, or acting on behalf of their counselling and psychotherapy organisations, will take this opportunity to highlight their achievements and share their success stories with others.

In this year's awards, BACP will be looking to recognise individuals or services in the following categories:

### Innovation in counselling and psychotherapy

This category aims to recognise and celebrate innovative work which has:

- increased access to therapy within a community
- helped to better meet the needs of clients and potential clients
- challenged thinking or adopted new techniques or models within a specific therapeutic setting/sector.

### Commitment to excellence in counselling and psychotherapy

This is an evidence-based practice award and aims to:

- reward an individual/organisation who

which demonstrates evidence of their long-term commitment to improving quality of life through therapy within a community, group of individuals or organisation

- recognise counselling and psychotherapy projects, initiatives or services that demonstrate consistently high standards and excellence in counselling and psychotherapy practice. (All applications must include supporting evidence/results.)

### Promoting the counselling and psychotherapy profession

This category aims to recognise an individual or service that has:

- proactively promoted the profession to the public with the aim of increasing positive attitudes towards therapy
- raised awareness of the benefits of therapy or their service within a community.

### Outstanding research project

This category aims to:

- reward excellence in counselling and psychotherapy research
- enhance awareness of the evidence base for counselling, psychotherapy and its guiding principles
- improve the overall quality of counselling and psychotherapy research by example.

To apply, please email [awards@bacp.co.uk](mailto:awards@bacp.co.uk) or tel 01455 883300 or visit [www.bacp.co.uk/awards](http://www.bacp.co.uk/awards). The deadline for applications is Monday 15 August 2011.

## News in brief

- A report by Carers UK shows there are half a million Black Asian Minority Ethnic (BAME) carers in England. *Half a million voices, improving support for BAME carers*, explains that BAME carers face additional difficulties, such as struggling with language barriers and accessing culturally appropriate services, putting them at greater risk of ill health, poverty, and social exclusion. *Source: Carers UK*

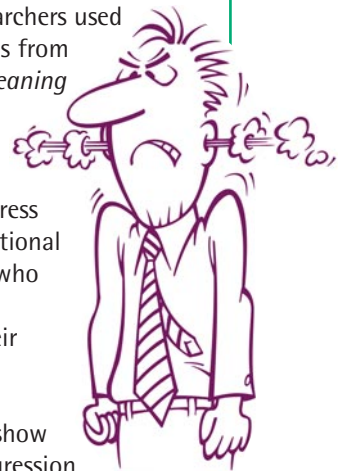
- New guidance from The National Institute for Health and Clinical Excellence (NICE), *Psychosis with coexisting substance misuse: assessment and management in adults and young people*, offers best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. *Source: NICE*

- Bottling up emotions could make people more aggressive, a study has found. Researchers used disturbing scenes from the films *The Meaning of Life* and *Trainspotting*

and asked some subjects to suppress or show no emotional reaction. Those who were allowed to demonstrate their revulsion at the scenes were far less inclined to show exaggerated aggression. *Source: Clinical Psychology News*

*Source: Clinical Psychology News*

- Cleaning could be making people depressed. So says a study that has linked offices and homes which contain lower levels of dirt and bacteria to weaker immune systems and, in turn, brain function impairment. The study suggests weaker immune systems tend to over-react to dust and dirt in the form of inflammations/allergies which can slow the brain's production of 'happy' chemicals such as serotonin, and cause depression. *Source: The Daily Telegraph*





## Healthcare in transition: strengthening our professional identity

BACP Healthcare seminar 2011

Are you fully aware of policy updates and developments in the counselling and psychotherapy healthcare sector? What do we mean by the terms 'counselling' and 'psychotherapy'? What is our role in the face of further changes to come, and do we need to re-establish our professional identity?

You are warmly invited to join the BACP Healthcare Executive at a seminar planned for autumn this year, which aims to explore these questions. The purpose of the one-day event, which will take place in York in the autumn, is to inform members of developments and reforms in primary care at a time of anxiety which started with the introduction of the Improving Access to Psychological Therapies (IAPT) programme and is likely to continue in the face of policy changes to come.

Aimed at practitioners employed and contracted by the NHS in different settings, the day will equip practitioners to play a part in driving the future agenda, and will link in with developments regarding GP commissioning: what does it mean? What will it look like? How can we prepare for it?

The seminar will also provide a forum for members to share directly with BACP Healthcare any challenges they are facing in their role as healthcare counsellors and psychotherapists. During the day, with feedback from services and individual members, we hope to find ways to celebrate our identity, as well as consider how to define our roles and evolve as a profession.

We look forward to seeing you there.

To register interest (or for more information and costs when available), tel Jessica Baxter on 01455 883321 or email [jessica.baxter@bacp.co.uk](mailto:jessica.baxter@bacp.co.uk) ■



**Ignore, append  
or integrate:  
*how do you use yours?***

**Nic Streatfield considers differing therapist attitudes to outcome measures, and argues that their active use can greatly benefit clients**





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Recent research by mental health service users detailing their experience of psychological outcome measures stressed the importance of the social skills of the mental health professional asking the questions. The study also recommended that mental health professionals should be properly trained to administer the questionnaire<sup>1</sup>. How many health professionals reading this would say they have been properly trained to administer the outcome measures they have been asked to use?

There is a wide range of psychological outcome measures available. The National Institute of Mental Health in England (NIMHE) published an *Outcomes Compendium*<sup>2</sup> rating 188 measures. These range from general measures of psychological wellbeing such as Clinical Outcomes in Routine Evaluation (CORE), to disorder-specific measures such as the Impact of Event Scale – Revised (IES-R) for PTSD. The increased interest in using outcome measures however, is not concerned with their quantity, but the changing way they are being used. The drive of successive governments to save money and increase accountability has created a strong trend towards measuring the outcome effectiveness of all health services. The NHS has to provide the best outcomes for the least cost, a mantra that is likely to intensify over the next decade as rising populations squeeze current budgets even further.

The Improving Access to Psychological Therapies (IAPT) programme is an example of a healthcare system seeking to provide accountable cost-effective therapy. One of the central tenets of IAPT has been the systematic use of outcome measures, and the Department of Health (DH)<sup>3</sup> recommends that IAPT services focus on collecting patient-reported outcome measures at each clinical session as part of a commitment to quality and productivity, as well as providing vital evidence to commissioners and others in demonstrating the return on investment made in services that are benchmarked against clear outcome measures. It stresses: 'This data is intended to be primarily useful to patients in providing tangible evidence of the progression they are making through their care pathway; and to

their clinicians in monitoring and developing their skills, and as part of the clinical governance process.'

This is a laudable statement from the DH and sounds as though it is a win-win situation. Yet the practice of collecting patient-reported outcome measures every session can be quite a cultural change for many and is always a challenge. I have experienced this challenge both in my role as a cognitive analytic (CAT) therapist working in a higher education setting and as a business development manager for CORE supporting both IAPT and non-IAPT services in establishing routine outcome measure collection.

In this article I will introduce three types of engagement with using outcome measures. I will discuss therapist resistance and ways to overcome this and talk about my own practice, where I believe my active use of OMs greatly benefits my clients.

### How therapists use outcome measures

It is often a difficult process to ask people to change their established ways of working. Therapists can be wary of the reasons why outcome measures are being introduced. Management may explain outcome measures are needed to increase accountability and transparency, help patient choice, and help managers to improve services, supervisors to help staff, and commissioners to commission services, but many therapists can view their introduction as a 'top down' imposition that will serve only to hinder their practice.

Yet I take the opposite view: that if outcome measures are used carefully, deliberately, and collaboratively with the client, then they will aid therapy, not hinder it. This is a view supported by Duncan<sup>4</sup>. 'Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximises therapist-client fit and client participation, and is itself a core feature of therapeutic change.'

However, to learn to use outcome measures effectively as part of the therapeutic process requires a certain proclivity. If the measures are not valued by the therapist, it is easy to

‘If OMs are used carefully, deliberately, and collaboratively with the client, then they will aid therapy, not hinder it’

see how they may be ignored. If the measures are seen simply as an administrative chore, then the measures may be only half-heartedly appended to the beginning or end of the session. It is only if therapists can develop ways to integrate the measures into their everyday practice that the multi-level benefits as envisaged by the DH will be generated. Therapist attitudes to outcome measures are really important to understand and people tend to fall into one of three categories:

- *Ignore* and hope you are never asked to do them. Some therapists, whether through a belief that collecting outcome measures in session will get in the way of the counselling process, or because of their own anxieties about the measurement of their performance, view outcome measures as an irrelevance or a threat, so they ignore them. If management do not spot this or also choose to ignore it, then many of the benefits of the measures will be missed. This attitude does bring to mind one of Winston Churchill's acerbic remarks, 'However beautiful the strategy, you should occasionally look at the results'. In one IAPT service I have worked with, there was a concern that the clients wouldn't like doing the measures, so they asked for an exception list to be created. This allowed therapists to choose a reason why the client did not complete the required outcome measures. CORE provided a data review workshop for the service and saw that the exception list was rarely completed. The exception was one unlucky outlier who had an enormous number of clients who seemingly had told the therapist that they didn't want to complete the IAPT measures. When management went to discuss the issue they found that it was the therapist who was very resistant to the use of outcome measures, not the clients.

- *Append* and keep the measures separate from the therapy. Therapists who fit into this category do follow instruction and collect the measures but they do so with no great enthusiasm. They might see the collection of the measures as solely an administrative task, so they simply append them to the beginning of sessions without discussing with the client what their answers mean to them or reviewing the client's progress or lack thereof. Perhaps they simply refer to the risk indicators on the form or maybe make assumptions about the client by only looking at the total score. Most outcome measures ask pretty challenging questions of the client and it seems plain rude to not discuss their answers with them. By not actively using the client's outcome measures, does this not convey the message to the client that it is not relevant to the therapeutic process? And if the client does pick up this message, how will they feel about being asked to complete it again and again?

- *Integrate* the measures into the therapy. This is the way I believe will be most successful in helping clients get better. I think outcome measures need to be used actively and collaboratively to improve the therapeutic experience and allow the therapeutic dyad to be able to visually monitor the client's progress. Just as we wouldn't hesitate if our GP asked to check our blood pressure every time we visited the

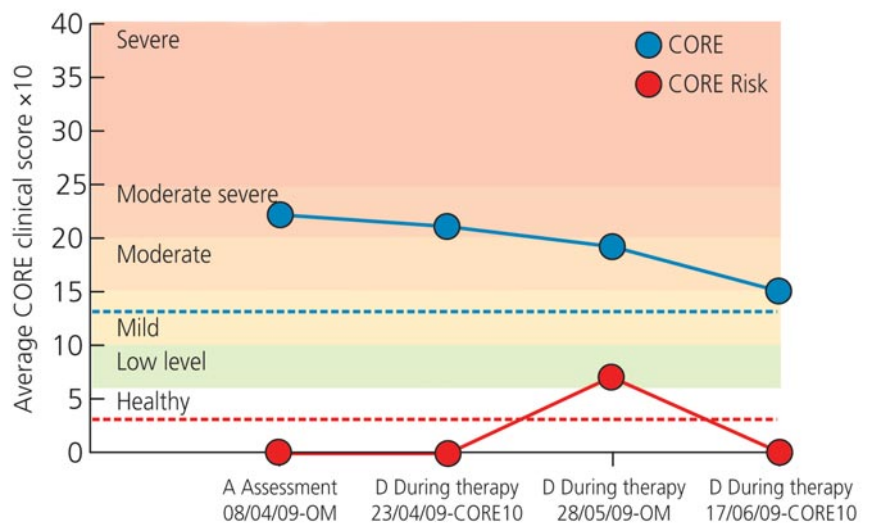
surgery, so my clients now expect to complete a CORE measure and expect the measure to be a springboard for a creative conversation. After all, the client has invested time in answering these often difficult questions and it is another part of their voice.

### Using measures effectively

I do not have space here to provide a comprehensive discussion of all the ways that using outcome measures can be used beneficially, so I have picked three examples:

1 *How was it for you to complete? Where do you think you might be on the chart?* These simple questions often open up into really interesting discussions about the client's current sense of self eg if a client thinks they have scored badly this week but the chart indicates a more positive result, then the conversation would be about that dichotomy and is always an insight into how they see themselves.

2 *Discuss the trend lines on the summary chart.* This visual representation is a tangible tool to help to collaboratively talk about when things are not going well, stagnating or improving. The client and therapist can easily view and reflect on current progress. Hawkins et al<sup>3</sup> found that providing feedback data on treatment progress to both clients and therapists was associated with statistically significant gains in treatment outcome.



CORE Net progress chart



3 *Reflect on the client's scores.* I have found outcome measurement to be an excellent addition to help me reflect on my work, both in looking back on what I might have missed in individual sessions and also on my overall performance. I have used my outcome data to focus my continuing professional development (CPD) activities to improve areas of my practice.

NIMHE's support of collecting patient-reported feedback states: 'Perhaps the most important reason is that it is the right thing to do in order to provide good treatment and care which can continually improve. Reflective practice requires us to get better at measuring the things that matter so that progress for individuals who use services (as well as the service provision itself) can be properly understood.'<sup>5</sup>

As a therapist myself I have experienced the often anxiety-provoking journey along the feedback trail (see *Nic's personal journey*). I don't know how else it could be for anyone seeking to change their practice. Often as anxiety levels rise, so too does therapist resistance. It is being able to work through this resistance that is the key to services, and individuals, moving towards the *Integration* stage.

### Reasons cited for not using measures

I have heard many reasons why therapists say collecting outcomes will be detrimental to clients. Pick your favourite:

#### 1 *I don't have enough time to do the measures*

New technology means clients can directly enter the data on a computer either in the session or before it. When therapists see the benefits to clients of using outcome measures then they make time because the process becomes an integral part of the therapy.

#### 2 *The client will not like it*

The data available from a range of services using CORE Net, the web-based clinical management system, suggests 82 to 93 per cent of clients are either 'quite happy' or 'didn't mind' being asked to complete the

measures. Overall, clients are much more positive than their therapists about the use of CORE Net<sup>6</sup>.

#### 3 *It will threaten the therapeutic alliance*

I have found in my own practice and through a small practitioner research project<sup>4</sup>, that because the outcome measure is a tangible tool, its collaborative use can help develop a shared focus and speed up the establishment of a good alliance. Miller, Hubble and Duncan's *Supershrinks* paper<sup>7</sup> claims that providing therapists with real-time feedback improves outcomes by nearly 65 per cent. Dropouts, the single greatest threat to therapeutic success, are cut in half. At the same time, outcomes improve yet again, in particular among those at greatest risk of treatment failure.

#### 4 *The outcomes may not really reflect how much my clients have been helped*

This is very true and is the reason why outcome measures are not the only way successful therapy should be judged. However, by taking an interest in your results this can increase your confidence and help you to see where you can improve.

#### 5 *The data will be misinterpreted and misused by managers as a stick to beat therapists with*

This depends on the manager. However, if you take a keen interest in your data, you will know what it is saying better than anyone else. Knowing where you are working well and where you need to improve is fantastic reflective development.

### Introducing and embedding measures into services

It takes courage to make changes to practice and for these to be successful requires a cultural shift when all stakeholders are persuaded of the use and relevance of outcome measures. It helps if the beneficial reasons why the measures are being used are properly explained to staff and to clients. In my experience many services simply tell their staff that they need to collect outcome measures and expect that to simply happen. The reality is that the move to successfully embedding outcome measures into

practice is a journey that can take three years or so. Simply deciding to implement a measurement system is not enough. A common mistake is for planners to focus solely on the technology or administrative systems being implemented. Instead, experience teaches that the leverage for a successful organisational change of any kind is to focus on the people. Winning over the sceptics is critical.

If there is staff resistance, there are likely to be therapists *Ignoring* or at best *Appending* outcome measures so the data quantity and quality can often be poor. If this is the case, then the usefulness to the individuals and the service is limited. This can be dispiriting and lead to increased resentment of the measures, thus reinforcing the resistance. Yet rather than let this downward spiral continue, careful planning can lead to an improving data cycle. Find those dynamic individuals who are *Integrating* outcome measures into their daily work, spread that enthusiasm and best practice, provide training and ensure management use the data positively, as this will help increase the value of the measures to all.

Orlinsky and Ronnestaad's research<sup>8</sup> emphasises the importance of continued therapist development. Paying close attention to your own outcome data is but one way of doing this. It helps to reflect on and question your current practice. For example, a few years ago I had a sense that I was seeing a high number of depressed men. I was able to interrogate my CORE data to see that, unusually, I saw more men than women (the service norm at the time was two women for every man). I could also see that I was not as effective helping depressed men as I was with other presentations and this allowed me to tailor my CPD to address this.

“The dialogical possibilities that emerge from outcome measures are the reason I have integrated them into my therapy”

## Nic's personal journey

When I first collected outcome measures, it was in paper form and the paper was processed by the administration team, often many months after the clients had left my therapy room. I didn't know quantitatively how many of my clients were improving. I didn't know much about the validity or reliability of the measure I was using, and I certainly had never been told how to use it effectively.

It is never a good idea when you are new in a team to agitate for change but that is what I did. Surely it should be the therapists who enter the data onto the reporting software as it would mean much more to us? Therapists would see a real person reflected in the data, not just the set of numbers admin did months later.

This process, with its inevitable resistance, meant that suddenly the data was accessible and it allowed me a different way of reflecting upon my client. I noticed areas (eg sleep problems) I'd hitherto neglected, and armed with the outcome measure, could go back and ask the client to explain more.

The ability to analyse my own data made it seem much more real for me. I was then fortunate to be involved in a small Practitioner Research Network (PRN) where we wanted to test how clients reacted to being asked to complete an outcome measure, not just pre and post therapy, but during it as well. At the time it felt revolutionary and was certainly anxiety-provoking. All of us were worried that it might threaten the alliance, yet it did the opposite, and our clients seemed to really like being able to track their progress and talk through their answers.

I did worry I might be 'found out' to be a hopeless therapist, but my data suggests that I'm doing OK. The challenge of systematic feedback though is that there is always more to learn. It can still be hard when a client is not improving and, while difficult to admit my input is not being helpful, being able to recognise it and discuss it seems to be extremely useful for the therapeutic process.

As technology has improved, I can ask clients to enter data themselves directly onto CORE Net either in the room, where I find people's physical response to the questions fascinating, or they can complete the measures in the waiting room, or even via email. It is not the numbers that interest me, but the reasons why clients scored the outcome measure that way at that time: the dialogical possibilities that emerge from outcome measures are the reason why I have integrated them into my therapy.

It is taking that anxiety-provoking step and being curious about how outcome measures can help the client and the therapist that seems to be the starting point on the feedback freeway. Unsworth et al's study<sup>9</sup> found that although therapists were initially resistant to routine outcome measure collection in principle, through practice and over time, they could see the benefits. For example, the therapists became more aware of the need to provide ongoing evaluation of their clients' progress; clients were more positive about using routine outcome measures and they particularly liked the visual presentations of their mental state.

For this virtuous circle to begin, therapists are required to pay more attention to how they use outcome measures with clients. The systematic collection of client feedback will not adequately happen if therapists *Ignore* or *Append* the measures to their work. Therapists who integrate outcome measures into their everyday practice do so because they have found ways to make it relevant to their therapeutic work. They see that the measures complement clinical judgement, not replace it. They see that clients respond well to being able to track their progress. This positive attitude is likely to be conveyed to the client, who then also sees the value of the measures,

the results they show and the curious conversations they generate. They are seen as a normal, helpful and integral part of therapy. ■

*Nic Streatfield currently works for CORE IMS as a business development manager and for the University of Sheffield as a counsellor. He also has a small cognitive analytical therapy (CAT) private practice. Nic has spoken at conferences on the active use of outcome measures in therapy and, through CORE IMS, provides training on introducing and using outcome measures.*

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### Reader response

*HCPJ* welcomes feedback on this article. If you would like to contact Nic Streatfield, or *HCPJ*, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)



# The testing **DIET**

**Tina Thomas** shares her knowledge of best practice and guidance in testing procedures

Is your testing protocol wobbly? Is your testing procedure fit for purpose? How sure are you that your testing boundaries have not become a little stretched and squeezed with everything else you need to fit into a session? Summer is here and after all that holiday indulgence it's time to put your testing on a diet! Whilst we all know that dieting is never easy or something we look forward to, it will become increasingly difficult to avoid focusing on this issue. The world of testing is moving into a more integrated and streamlined practice that includes the development of benchmarks and competencies to cover all aspects of test use regardless of their context.

In 1995, the International Test Commission (ITC) broadened its work to encompass a responsibility to produce international guidelines on the fair and ethical use of tests<sup>1</sup>. These guidelines are intended as a benchmark for the training and competencies that test users are expected to achieve. Internationally it was felt that these guidelines were needed as countries differed greatly in the way in which they used tests and the standards to which test users were expected to adhere. The regulation of who has access to different tests for use in different countries also differed greatly. Potentially this could result in individuals being treated differently and, therefore, possibly unfairly, in different geographic locations. The production of these guidelines was a multinational collaborative project and at the Council of the International Test Commission meeting in June 1999 the guidelines were formally adopted as the new international standards for test use. The European Federation of Psychologists' Associations' (EPPA) Task Force on Tests and Testing<sup>2</sup> (now the EPPA Standing Committee on Tests and

Testing) established in the Athens meeting, 1995, also endorsed the guidelines at its July 1999 meeting in Rome. The British Psychological Society's (BPS) Psychological Testing Centre (PTC)<sup>3</sup> is nearing completion of its new training programmes for qualifications in testing which is based on the ITC guidelines for best practice in test use.

The international guidelines should be considered by all who use any form of testing in their work as benchmarks against which their existing standards can be compared. The guidelines' key purpose is to provide a framework that can be used to ensure that all test users will use tests in a professional and ethical manner whilst respecting the needs and rights of people involved, the purpose of the test, and the broader context in which the testing occurs. The guidelines recognise that the terms 'test' and 'testing' are used in a variety of contexts and ways that vary greatly given the scope and purpose of the assessment. However, they are clear that these guidelines apply to all situations where assessments take place, even those that do not involve procedures that are called a 'test'. The guidelines therefore apply to any procedure used for 'testing', regardless of its mode of administration; regardless of whether it was developed by a professional test developer; and regardless of domain or context. This explicitly includes procedures for use in psychological, occupational and educational assessment, and procedures for the measurement of both normal and abnormal or dysfunctional behaviours. The following 'diet' is not intended to give you an exhaustive and definitive guide to best practice but rather to give you an overview of the practical elements of the guidelines that will enable you to make some easy changes, if necessary, to streamline your own work in this area.



**D... is for data protection**, and this does deserve its capital letter! As part of the benchmarks for ethical practice fall under the Data Protection Act (1998)<sup>4</sup> in this country, it is not a guide to best practice here but a statutory requirement of how you treat, store and handle other people's personal data.

The Data Protection Act is based on eight principles. The first of these is that personal data shall be processed *fairly* and *lawfully*. This could be seen as fairly open-ended. However, it does go on to state that data cannot be processed unless that data meets the second and third principles of the Act: personal data shall be obtained only for one or more *specified* and *lawful* purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes; and that in the case of sensitive data the information stored should be *adequate*, *relevant* and *not excessive* in relation to the purpose or purposes for which they are processed. In practical terms this means that clients

must be told the purpose of the testing session and that you should only collect and store data from this session that provides an accurate assessment of that purpose; collects information that is relevant to that purpose; and does not contain information that is not relevant to that purpose. The importance of being clear about the purpose of the testing is an important issue.

For the purposes of the Act, this data handling is termed 'Processing' and it includes the *obtaining, recording, holding or storing* of information in any form; and carrying out any operations on the data, including *adaptation, alteration, use, disclosure, transfer, erasure, and destruction*. These are important distinctions to make as you may be required to submit a summary of the data you have collected in another form, for example, into an electronic data base. The rationale for this needs to be quite clear; you must be sure that not only do you understand what will happen to this data (what purpose it will be used for in the future), how it will be stored (whether it is anonymous), and how long it will be kept for, but also you need to convey this to the individual the data relates to. This will be elaborated on later in the article.

“The guidelines to good practice do state that any test results should only form a part of any decision-making process as they are all subject to a margin of error and some degree of fallibility”

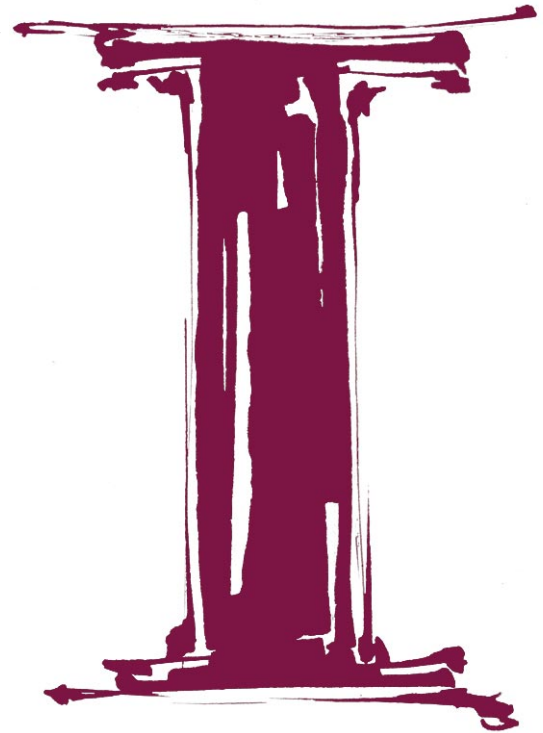
The fourth principle dictates that any personal data held will be *accurate* and, where necessary, kept *up to date*. If the data held becomes outdated in terms of serving its original purpose in any meaningful way then we must

question the validity of keeping it. To this end the fifth principle specifies that any personal data shall *not be kept for longer than is necessary* for that purpose or those purposes. Again this may seem a little open-ended but if the data held no longer contributes to the original purpose, or perhaps has been stored in another form (eg electronic), we have a duty to securely and confidentially destroy whatever is no longer needed. As a rule of thumb and where it is the case that historical personal data is no longer needed, a period of six months is the norm for paper-based test results storage. There should be regular reviews carried out of the stored data to ensure that data is not held for any longer than is necessary.

The sixth principle of the Data Protection Act states that any personal data should be treated in accordance with the *Rights of Data Subjects and Others* under this Act. The act itself conveys rights to individuals in respect of the data held about them. The individual is entitled to be supplied with a copy of all personal data held. No personal data should be held or obtained unless they have given their consent, and this must only be held and obtained in relation to the stated purpose. Principle 7 specifies the measures that can be taken against unlawful or unauthorised processing of personal data which includes *accidental loss or destruction of, or damage to data held*. The unlawful and unauthorised use also includes *direct marketing* and any actions deemed to *cause damage or distress*, including any decisions made on the basis of the data held. A point worth considering here is being clear not just about the purpose of the testing session but also the purpose of the test itself. If a test has been designed as a screening tool, and not as a diagnostic tool, make sure that any treatment decisions are able to be evidentially based on a broader set of information rather than the test results themselves. In fact, the guidelines to good practice do state that any test results should only form a part of any decision-making process as they are all subject to a margin of error and some degree of fallibility.

The eighth principle dictates that

personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

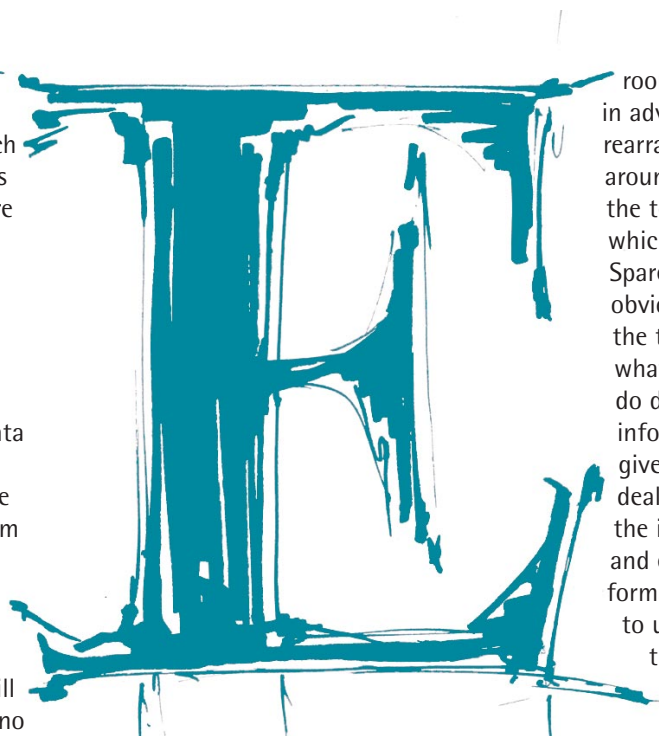


**... is for informed consent.** This extends the minimum requirements embedded in the principles of the Data Protection Act to include additional guidelines on how individuals involved in testing should be treated fairly and ethically. A fundamental point here is that the individual feels that they have been adequately informed, not that you feel you have given them adequate information. To this end managing the whole process of the testing session has to be based on ensuring this is the case. The easiest way to manage this is to provide clients with an information sheet that not only details the items required for data protection but also tells them about the test, how long it might take, whether there are right and wrong answers or whether the test just asks for their opinion, and what kind of things it asks or is assessing. Without this they cannot know what they are expected to do. It is not sufficient to just tell them that they will be doing a test on depression and



anxiety, for example. The very idea of testing can invoke stress or anxiety so giving your client as much reassurance about this not only puts them at ease but means that you are less likely to get socially desirable rather than honest responses.

In respect of the data you are collecting from the test, the client needs to know what will happen to this. Not only is this necessary from the point of consideration of the data protection issues but is also best practice in giving information to the client. You will need to reassure them that any data will be held securely and that no other person will have access to this, unless they have consented otherwise. Confirm that any paper form of data collected will be destroyed as soon as the data is no longer required and how, if appropriate, the data is going to be adapted or transferred and then held. Will it be anonymous? What will it be used for? It is expected that if the data were to be utilised in this way that it would contain no information that allows the data within to be attributed to any individual, or for them to be identified from it. The electronic form of the data should only be held until it is no longer needed then securely destroyed. Using data to create norm groups or other reference groups from it is perfectly acceptable but only if your client is aware of this and is told why and how the resultant data is treated before consenting. Think of this as a form of contracting for testing with your client in the same way you would for therapy. They must know what the information will be used for (ie for discussion during their session or for benchmarking progression of symptoms etc) and have the opportunity to ask any questions about the information they have been given before completing the test. If the test is not being completed in a face-to-face setting because the client is expected to have the test completed in advance of your session, then the required information should be sent to the client before or with the test. This should then also have contact details included in case the client wishes to ask any questions or have any queries in advance of test completion.



**E... is for environment**, the actual setting that the testing takes place in. This is different in different settings. Assuming that the testing is in a face-to-face situation, then certain considerations as to the effects that the environment can have on the accuracy and validity of the test results need to be considered. Almost all tests can have a margin of error in the results. If the test-taker had completed the test on a different day or in different circumstances, the results may vary slightly. This margin of error is not likely to yield a significant movement away from the original test result if the test is reliable and properly constructed; however, the setting up of the testing session and the distractions that may occur should be minimised in order to ensure that the test results you obtain are less likely to differ in this respect. This may be particularly important where the test has been designed for diagnosis and you need to be able to demonstrate, from a data protection point of view, that the test was carried out in as robust a manner as possible to ensure the utmost accuracy of the results. The obvious distractors are noise, excessive or insufficient heat and light, and interruptions.

There are also factors that relate to the individual that you may not be able to control but perhaps are able to note for reference, such as mood, hunger and tiredness. Having the

room set up appropriately in advance with no need to rearrange furniture or move around in order to carry out the test can reduce anxiety which may affect test results. Spare pens and papers seem obvious as does checking that the test-taker understands what they are expected to do during the test from the information they have been given. A best practice way to deal with this is to read out the instructions to the client and explain the response format they are expected to use. If appropriate, give them an opportunity to do some practice questions and to ask

any questions about these afterwards. Of course if the testing is to be carried out prior to the session and in their own time, you may want to consider giving them instructions to try and find a time and a place that is free from as many distractions as possible to do the test.

“The effects that the environment can have on the accuracy and validity of the test results need to be considered... If the test-taker had completed the test on a different day, or in different circumstances, the results may vary slightly”

Think about when in your session you are going to carry out the test – will they know they are going to be doing a test in advance of coming or not? Will the test be carried out at the beginning of your session, and used as a basis for discussion, or at the end of the session? If it is going to be done at the end then some level

of feedback is needed to reduce anxiety about the test results before the next time you see them, giving a form of closure on them. If the testing is carried out partway through the session, it is possible that the prior discussions you have had influence the answers they may give. If the testing is to be repeated to monitor symptoms or progress, it should be placed at the same juncture in the session as previously carried out and any effects of repeated exposure, ie learnt answers, should be investigated in discussions and noted.

### T... is for issues relating to the testing itself.

All tests are designed for a purpose: at a very basic level do you know what your test was designed to measure? There are multiple measures of many constructs: depression, anxiety, ability, etc. These will have been designed and constructed using different populations and for different purposes (ie screening vs diagnosis). They will have differing reliability and validity statistics in different populations. Are you, for example, comparing minority group

members' results to a norm group that was created using white, middle class American males?

Using this information that is available in published articles and test manuals can help to ensure that the test you are using is the most appropriate for your client. This will not only allow you to obtain the most robust test results but also give you a finding that is most relevant to your client needs.

The characteristics of your clients themselves are also important considerations: testing people with disabilities needs particular attention in testing practice. If your client has a disability that may affect their ability to understand and/or respond appropriately to the test

information and you do not account for this, you could be drawing invalid conclusions from the test results you have gained. In respect of issues such as dyslexia and dyspraxia, reading the instructions to aid understandability and practice questions, as discussed above, will help. For other disabilities a case-by-case judgement must be considered and if deviations are made from a standardised approach as advocated by the test publishers, such as different response formats and more simplistic language in the questions asked, these should be justifiable and noted for future reference, if needed. If the deviations are likely to significantly detract from the reliability and validity of the test results, then alternatives should be found. If in doubt, it is recommended that you contact the test publisher directly and/or refer to the information in the test manual.

A final word on issues surrounding the test relates to the standardisation of the test procedure. The tests you use will have certain response formats and instructions to follow, perhaps for both you and your client. It is important that you do not vary these in a way which changes their meaning; it is the client's interpretation that is needed. In order that the test results have a good degree of rigour it is important that each participant's experience of completing the test is the same, particularly where the tests results are being used to create a norm group or some form of pooled comparison population. ■

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#### Reader response

Was this article useful? Will it help you to make changes to the way you test?

Do you have any further questions?

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“If your client has a disability that may affect their ability to understand and/or respond appropriately to the test information and you do not account for this, you could be drawing invalid conclusions from the test results”



# Recognition of depression and distress in primary care: are clinical skills adequate in the absence of screening?

How well can clinicians diagnose depression using their day-to-day clinical skills? Research by **Alex Mitchell** and colleagues examines diagnostic capabilities without the use of screening tools

A variety of expert guidelines have addressed screening for depression, but unfortunately few agree, leaving most clinicians uncertain what approach to take<sup>1,2</sup>. Impressive data from the US suggests that without incentives, screening for depression takes place in only three per cent of primary care consultations<sup>3</sup> and in about one per cent of consultations with specialists<sup>4</sup>. In the UK, the 2006 *Quality and Outcomes Framework* (QoF) specifically encouraged screening for depression in patients with diabetes and/or coronary heart disease (CHD). Two audits suggest that between 79 per cent and 84 per cent of patients with these conditions are screened for depression<sup>5,6</sup>. Outside of diabetes/CHD, rates of screening for depression in routine care survey data suggest that most clinicians are not using formal tools but prefer to rely on their own clinical skills<sup>7</sup>. The most important question, therefore, may be not how well do screening tools perform, but how well can clinicians diagnose depression using their day-to-day clinical skills?

## The diagnostic accuracy of GPs

Recently, our group undertook a meta-analysis in order to better understand the diagnostic accuracy of general practitioners (GPs) and nurses<sup>8,9</sup>. GPs have been subject to far more scrutiny in their diagnostic habits than any other professional

group, whereas nurses are the most numerous clinicians in the NHS. Both groups have a vital role as front line healthcare professionals in the management of mental health problems. We found 41 robust studies of GPs' clinical ability to diagnose depression, 23 of which regarded their ability to detect broadly defined distress, and nine reporting on mild depression. We located 22 studies regarding the ability of nurses to identify depression clinically. From these studies, both GPs and nurses correctly identified depression in about half of true cases although there was a correct entry in the medical records in about one third of cases.

Clinicians correctly reassured eight out of 10 healthy individuals but with substantial false alarms. In a typical urban practice (where the prevalence is 20 per cent) the error rate would be 25 per cent (10 per cent missed cases and 15 per cent false alarms). Although results are likely to be representative of most primary care practices, there is one important caveat. Data are generated from studies where physicians volunteered to participate in a study and were therefore aware of being observed and (presumably) trying to detect cases. It seems reasonable to conclude that these results may be unduly favourable compared to routine care. Indeed, in a handful

of retrospective studies where GPs did not know they were being observed, it was found that GPs would more typically detect only one in three cases, but correctly identify nine out of 10 non-depressed people. In other words, in the real world, there are likely to be more false negatives than false positives.

Yet these possible misidentifications are not necessarily errors unless they are followed by an inappropriate action. Indeed, we know that clinicians tend to prescribe antidepressants to people whose diagnosis is more certain. From studies of prescribing habits, we know

‘Impressive data from the US suggests that without incentives, screening for depression takes place in only three per cent of primary care consultations’



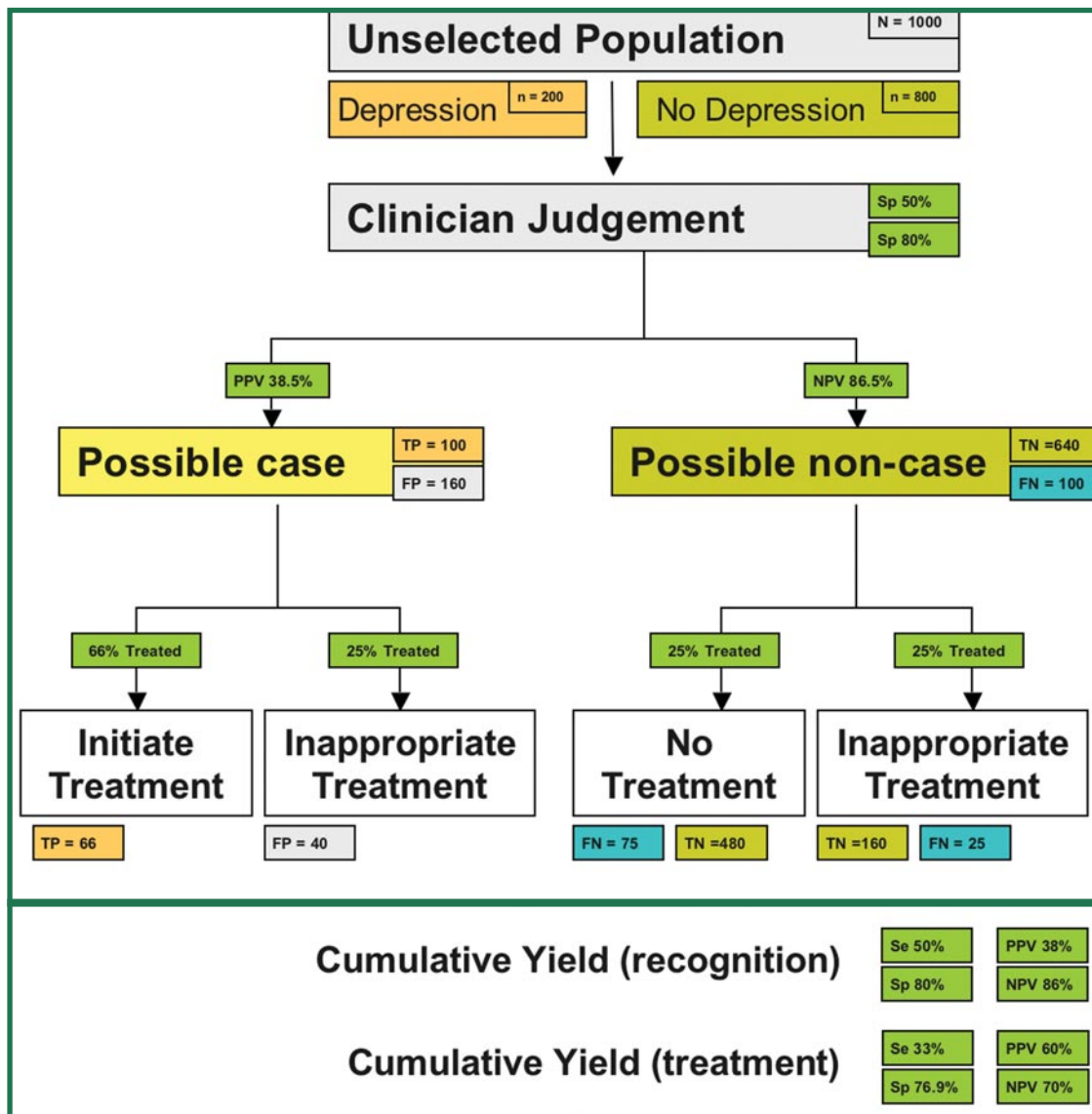


Figure 1. Illustration of yield from clinicians looking for depression in clinical practice

that GPs prescribe to about two thirds of patients in whom any depression diagnosis is recorded but only a quarter in whom either no diagnosis is recorded or those with very mild symptoms but still considered to be depressed<sup>10-12</sup>. Therefore, taking into account both the diagnostic difficulties and the therapeutic difficulties, then clinically the maximum proportion of therapeutic errors should be no higher than 10 per cent (those with no depression on treatment) plus 7.5 per cent (the missed cases who receive no treatment). This is illustrated in figure 1. Preliminary data from a recent survey of Scottish GPs appears to support this calculation<sup>13</sup>.

### Looking for distress vs depression

It has been argued that the reason for error is that astute clinicians increasingly look for distress rather than depression and hence focus on a broad spectrum of severity rather than the narrower major depression concept. Furthermore, mild depression is now recognised as important largely because of the prognostic implications, and the American term of 'minor depression' is becoming more widely accepted. Although it is certainly the case that distress is an increasingly popular screening target, largely due to the high acceptability and understandability

of the term, it cannot be assumed that GPs correctly target this condition. Our group recently examined whether GPs were really able to accurately identify distress as well as mild depression<sup>14</sup>. We found that detection of mild depression was inferior to the detection of more severe depression, which is intuitively correct because differentiating mild from normal depends on fewest symptoms or signs<sup>15,16</sup>. Furthermore, their ability to detect broadly defined distress was no better than their ability to define depression itself with about 50 per cent sensitivity and 80 per cent specificity.



Detection of	Prevalence of condition under study	Proportion of cases detected (GP sensitivity)	Proportion of non-cases detected GP specificity	GP predictive accuracy when they judge a case as present (PPV)	GP predictive accuracy when they judge a case as absent (NPV)	GP clinical ability to confirm the condition (CUI+)	GP clinical ability to refute the condition (CUI-)
Depression	20%	50%	80%	38.5%	86.5%	19.2% (poor)	69.2% (good)
Distress	40%	50%	80%	62.5%	70.6%	31.3% (poor)	56.5% (average)

PPV = Positive Predictive Value; NPV = Negative Predictive Value; Clinical Utility Index (CUI)

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Table 1. GPs' ability to detect depression and distress using clinical judgement

However, there was one major difference between looking for depression and looking for distress. Distress is at least twice as common as clinical depression (approximately 40 per cent vs 20 per cent) and this influences accuracy by reducing false positive errors but at the expense of false negative errors (see table 1). Overall, when both the frequency and the discrimination of clinical judgements are taken into account, clinicians have average to good rule out abilities, but rather poor rule in abilities.

Looking more closely at types of diagnostic error, many are underestimates or overestimates of severity rather than complete misidentifications. In many cases clinicians recognise symptoms but do not believe psychological issues are clinically significant<sup>17,18</sup>. For example, Tiemens and colleagues<sup>18</sup> found that only 26 per cent of missed cases (false negatives) were complete omissions whilst 25 per cent were underestimates of severity (eg diagnosing sub threshold instead of mild) and 38 per cent were misidentifications. Conversely of false positive diagnoses, 35 per cent were overestimates of severity, 24 per cent were misdiagnoses and 41 per cent complete errors. In the MAGPIE study,

One interesting observation is that the performance of individual practitioners varies considerably

Bushnell et al<sup>17</sup> found that reasons for failures in diagnosis were not categorising their psychological issues as clinically significant (23.4 per cent); recognising clinical significance but not ascribing a particular diagnosis (7.1 per cent); or the GP making an explicit diagnosis of something other than depression (7.7 per cent).

### Varying performance of individual practitioners

One interesting observation from these recognition studies is that the performance of individual practitioners varies considerably. In one of the most comprehensive studies to date, carried out in Australia, Hickie and colleagues<sup>19</sup> looked at 46,515 patients attending 386 GPs, of whom 56 per cent were not recognised as depressed. Patients were more likely to be assessed psychologically if they were middle-aged, female, Australian-born, unemployed, single, and presenting with mainly psychological symptoms or for psychological reasons. Doctor characteristics associated with willingness to assess were being aged over 35 years, having an interest in mental health, having had previous mental health training, being in part-time practice, seeing fewer than 100 patients per week, and working in regional centres.

Five other key factors appear to influence the ability of clinicians to adequately detect depression. The first is the ability to maintain appropriate clinical suspicion, that is, the propensity to look for the condition in question and act on verbal and non-verbal signals when presented. In an audiotape study by Adelman et al<sup>20</sup>, depression was discussed in only 7.3 per cent of medical visits. Of these, physicians

raised the subject of depression in 41 per cent of visits, patients raised the subject of depression in 48 per cent of visits, and accompanying persons raised it in 10 per cent of visits. Depression was raised almost exclusively in the first 2.5 years of the patient-physician relationship.

The second factor is physical comorbidity. If background somatic symptoms are incorrectly assumed to be depression, there is a risk of false positives, and if true depression-related somatic symptoms are ignored, there is a risk of false negatives. This issue can only be resolved clinically if the origin of somatic symptoms can be established, for example, by asking whether they were present before the depression began.

The third factor influencing diagnosis (or diagnostic disclosure) is the availability of effective treatment and, linked with this, the likelihood that a patient will accept the diagnosis and affiliated treatment. Effective continuing care is an important piece of the puzzle that influences prompt diagnosis in a subtle way. In short, if no effective and acceptable treatment is available then physicians are reluctant to give a diagnostic label, even if that label is medically accurate<sup>21</sup>.

A fourth factor in the difficulty dealing with depression in primary care is that a surprising number of people with clear distress or depression do not accept professional help and this influences whether clinicians use the diagnosis<sup>22,23</sup>. For example, Walters and colleagues<sup>24</sup> found that only half of participants reported wanting help. Most preferred informal sources of help such as friends/family support, and complementary treatments, together with general advice from their GP.

Primary care and mental health services need to continue to develop ways of helping people who decline initial help, for example, by offering self-help tools, bibliotherapy, internet programmes and open follow-up.

The fifth and perhaps most important influence on detection is having adequate time. The longer the consultation, the more comprehensive the assessment and the more likely a correct diagnosis will be made<sup>3</sup>. Unfortunately many clinicians are pressured to use short appointments, often the result of an organisational push for quantity at the expense of quality.

## Conclusion

In conclusion, both depression and distress can be both under-detected and over-detected. However, it is important to acknowledge that depression can be difficult to diagnose accurately using existing criteria and it is not clear that primary care physicians perform any worse than other medical colleagues. Current criteria are somewhat arbitrary and difficult to remember. A relatively new approach is to start with broad concepts such as distress and then assess unmet needs and desire for professional help. This approach is not uncommon in clinical practice and is being formally tested in screening studies. Several groups are also trying to use evidence to develop simpler criteria for major depression that are memorable, but still clinically meaningful<sup>25</sup>. ■

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## Reader response

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# Electronic patient records: the impact on the therapeutic relationship



**Brian Rock** and **Helen Brindley** look at confidentiality issues arising from the use of electronic records, adding a consideration of the subject from a psychoanalytic perspective

There is a noticeable dearth, certainly in the UK literature, of clinical perspectives on record-keeping generally and on the impact on the therapeutic relationship specifically. To illustrate, one need only refer to the helpful record-keeping guidelines published by the British Psychological Society<sup>1</sup>. Of the 64 publications referenced, the majority are policy directives from the Department of Health (DH) and most of the remaining references are guidelines issued by professional bodies. This is especially noteworthy given the introduction of electronic patient record (EPR) systems across the NHS. Colleagues frequently refer to the ever-increasing administrative load eroding time and space for reflection and processing of clinical material. In many cases, information is collected from patients in sessions, which is often felt to be intrusive and at odds with, or even disruptive of, the therapeutic frame. In some clinical situations, the attending professional spends more time looking at a screen or typing than engaging directly with the patient in the room. Nonetheless EPRs and all associated developments and/or impingements are certainly not going away. On the contrary, there is an exponential growth, making this a central feature in the work we do.

The issues, dilemmas, pitfalls and challenges posed by EPRs are not entirely new. Since 1992, there has been a raft of policy guidelines addressing various aspects of data collection, protection and dissemination – a bewildering array for the busy clinician to keep pace with. Of immense

importance is the guidance emanating from the Caldicott Report (1997) resulting from the review undertaken by the Caldicott Committee as it was called under the chairmanship of Dame Fiona Caldicott. The Chief Medical Officer requested this review in light of concerns about confidentiality as a result of the developing information technology. This report resulted in six key principles, including information being shared on a 'need to know' basis and 16 recommendations, which included the appointment of a senior person across health organisations to act as a guardian of patient confidentiality – known as Caldicott Guardians.

Other related developments include:

- Policy on copying correspondence aimed at facilitating the importance of greater service user involvement in treatment plans. This highlighted an interesting tendency to view information about physical health as synonymous with mental health. Moreover, different professionals in mental health do not necessarily see personal information in the same way.
- The centrality of the child protection and safeguarding adult agendas and the consequent responsibilities on the clinicians, which are often in conflict with ensuring privacy and confidentiality but exist for the greater good.
- More broadly the fact that we live in the so-called 'Information Age' (in which personal information is readily shared in all sorts of ways such as the internet) might lower sensitivity to breaches of privacy.
- Overvaluing of the notion that information alone can prevent harm to self or others.

Electronic patient record systems are certainly here to stay, though who knows what technological advances might lead to further developments away from what many clinicians already feel is a step too far in the management of the clinical domain. The focus of this article will be on the consideration of confidentiality and the inevitable clinical dilemmas that arise in the context of the local implementation of interim systems.

## Electronic patient records (EPRs)

The House of Commons Health Committee's report on *The Electronic Patient Record*<sup>2</sup> refers to the EPR as a 'potentially... transformative technology' but also recognises that personal health information is often 'highly sensitive' and it is '...therefore difficult to repair the damage caused by a breach of privacy'. There are some laudable aspects of the envisaged National Programme for Information Technology, contained in its plans for the Summary Care Record (SCR), such as the availability of sealed envelopes of information, specific data sets that could be life-saving and help integrate care in emergency situations, and of course the plans for greater service user involvement via the envisaged internet portal HealthSpace.

In a survey recently published by the new economics foundation (NEF) and the Centre for Science Education at Sheffield Hallam University (supported by the Wellcome Trust)<sup>3</sup>, 6,000 people were asked about their attitudes to the digitisation of records. Of those surveyed, 57 per cent of adults and 67 per cent of

young people were enthusiastic about the potential benefits to treatment and healthcare from moving to digital patient records. However, the vast majority of both groups believed that patients should be able to choose whether or not to be included in any digital database containing personal health data.

Almost all of those surveyed felt that patients should have access to their own records, but a much smaller number (35 per cent of adults and 36 per cent of young people) were in support of online home access; even fewer (11 per cent) supported proposals to enable patients to add

information to their own records.

Stephen Whitehead, co-author of the NEF report, said: 'The NHS holds incredibly private, sensitive information about almost every person in the UK, but *there is little public understanding of what happens to that information*. Unless the NHS takes decisive action to narrow the divide between public perception of how information is used and the reality, the use of electronic patient records risks seriously undermining public trust in its ability to protect confidentiality.'

We certainly do not decry the phasing out of paper files/records as we move to a paperless system;

however, many of the problems with paper records have attracted far less concern than is being directed at EPRs'. Paper files can be removed from the service, transported to another clinical base, can be incomplete/disorganised, or simply lost or stolen. Of course, there are also very real concerns in what represents a seismic shift in how records are now created, updated, stored and accessed. This is quite separate from the legitimate concerns about the technical and human fallibilities of the system – for example, is role-based access being effectively utilised? – and the questionable effectiveness of audit trails to track inappropriate record access. There is also a distinct gap between some of the aspirations of the national information technology (IT) programme and the realities of the interim systems that are in place at a local level.

One of the ways in which concerns have been negotiated about breaches of confidentiality and the sharing of information beyond the therapeutic context is through the existence of a separate clinical record for psychological work. Newton<sup>1</sup> clearly sets out in the guidelines mentioned earlier that this is not an option. However, there are contradictions contained in guidance issued within specific professional bodies as well as between professional bodies of different professions. Many mental health professionals hold dual registration, which adds to the complexity and impedes the individual clinician from knowing which way to turn.

### System of care

Increasingly mental health services are primarily team based, and in the mental health trust in which we work, management's perspective is that all parts of the patient record need to be accessible for the team to function safely and effectively. Given that there are no electronic sealed envelopes available, at least not in our trust, the question arises about how this approach to shared care is balanced

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against the accessibility of sensitive client information.

There is typically an understanding between therapist and patient that anything that the patient says will be treated in confidence unless the patient alerts the therapist to the risk of danger to themselves or others. What does this mean in the context of keeping a record that other team members will have access to? What guidance should be provided for therapists regarding what is included in the medical record and what should be kept out of the record?

Within community mental health teams (CMHTs) there is an expectation that all information will be shared within the team and patients are usually told that this is the way the service works. Therapists working as integrated team members have been concerned for a number of years about what amount of detail to record in the shared record. The dilemma is heightened by the electronic record where therapists may not be a member of the team, certainly as identified by the patient, but, by virtue of the ease of access to the electronic record, they suddenly are part of the virtual team caring for the patient.

Where in the past, referring psychiatrists would receive a discharge report summarising the progress of therapy and recommendations for future treatment, now they can access the record that the clinician makes every time the patient attends. Should the therapist comply with the requirement to make an entry by noting whether the patient attended and nothing more (even this degree of recording may be of concern in some circumstances where another involved professional may put pressure on a patient to attend)? Should the therapist limit entries to recording concerns about risk?

Barbara Mitchels and Tim Bond, in their excellent and comprehensive book *Confidentiality and Record Keeping in Counselling and Psychotherapy*<sup>5</sup>, describe how clinicians are often required to walk a 'tightrope' between preparing overly detailed notes and records that threaten to breach confidentiality and privacy, or keeping such brief, scant notes as to render them meaningless and without value.

Nonetheless, we are of the view

that information arising from the clinical encounter with patients should be shared with members of the treating team. Depending on the context, this might involve sharing information with colleagues in a psychological therapies service to facilitate the patient moving from assessment to treatment or indeed returning to the service after having completed a treatment or having been previously assessed.

The clinical team can also be spread across a number of separate services with more fluid boundaries, for example, where a patient is receiving psychotherapy in one service and CMHT input from another service. The wider team will also include managers and by extension commissioners, as well as referrers who may exist outside of one's organisational parameters and other involved parties.

EPRs tend to override these subtleties and nuances where all information is treated as having an equal value. This introduces a significant component governing whether information is shared, how it is shared and with whom: namely anxiety and our efforts to contain anxiety (through disclosure and through non-disclosure; often appropriate to the situation but perhaps manifest in breaches or barricades at other times). This raises an important question in relation to sharing information: is it better to have 100 people contain one per cent of the concern or anxiety or one person to contain 100 per cent? (Personal communication with Dr Rob, 2011.) This dynamic links to an inevitable and understandable tension in the clinical encounter that the patient and clinician has to negotiate – what is said, what is unsaid, and why.

### Confidentiality

*'Whatsoever things I see or hear concerning the life of man, in any attendance on the sick or even apart therefrom, which ought not to be voiced about, I will keep silent thereon...'* (Oath of Hippocrates).

Mitchels and Bond<sup>5</sup> define what confidentiality means within a therapeutic relationship: 'Confidentiality: to confide in someone is to put your trust in them. Confidentiality presupposes trust between two people within a community of at least three

people. In a professional relationship 'confidentiality' means protecting information that could only be disclosed at some cost to another's privacy in order to protect that privacy being compromised further.'

They explain that it is the privacy of the therapeutic space, the therapeutic couple and their dialogue, that confidentiality protects: confidentiality is a patient's right and the therapist's obligation. Confidentiality is an essential characteristic of the containing property of therapy. Without confidentiality, patients would feel constrained in what they could say or might feel that engaging in therapy was too risky until the need for therapy overwhelmed their sense of self-protection.

They go on to discuss the complex issues that arise when confidentiality is considered in the wider societal context, where there are competing moral interests. The way that legal and moral systems deal with confidentiality inevitably changes over time. With the conflicting interests, there is a risk that what appears to be simple and clear and what patients wish for is in fact far from straightforward and simple.

Where does the balance lie between avoiding deterring people from seeking therapy because of fear of breaches in confidentiality, and the benefits to society of enabling investigation and detection of serious crime even when this requires therapists to breach confidences? At what point do the principles of justice and fairness between citizens require that court cases are decided on the basis of all the relevant information being made available, even if this means intruding into what would otherwise be confidential? Should information disclosed in therapeutic confidence be given legal privilege to protect it from being required to be disclosed in court cases?

Therapists have the same legal obligations as doctors, ministers of religion, accountants and journalists. The right to confidentiality is enforced as a matter of benefit to society and can be overridden when public interest would justify this. The legal position is that there are times when the public interest in the disclosure of information outweighs public interest



in preserving a patient's confidentiality.

Mitchels and Bond helpfully outline the legal limitations of confidentiality:

- prevention of serious harm to self and others
- legal requirements – eg court orders
- disclosures to enhance the quality of services offered by the therapist (eg professional supervision or sharing information with colleagues in a team setting).

There are many less than clear-cut circumstances. For example, if a patient proposes to harm someone but there is no past history, then the therapist must make a judgement about risk (a therapist's inability to contain anxiety is insufficient grounds for a breach of confidentiality).

When deciding whether to breach confidentiality a therapist is required to make a considered judgement on the basis of:

- real risk – as opposed to fantasy
- serious harm – eg threat to life, rape, child abuse
- imminence – is it possible to take effective preventive action within the therapy?
- effective intervention – will a breach of confidentiality minimise the risk of harm?

Confidentiality is at the heart of the work of psychoanalytic therapists and with the implementation of electronic record-keeping there has been a great deal of unease among therapists who are contractually required to make routine entries to update the patient record but who remain concerned about the implications of this in terms of privacy.

Therapists working in the NHS are faced with conflicting interests. The analytic stance to protect patient privacy is at odds with the principles and procedures of NHS-managed care and requests for increasing amounts of information. Should therapists comply unquestioningly? There is an impact within the organisation given the changing nature of communication and the way information is held, with a pressure to increase openness and an erosion of privacy.

Within the mental health trust in which we work, all psychological therapists are required to make an

entry in the electronic record within 24 hours of contact with each patient. In addition the electronic record will contain:

- core assessment
- risk assessment – updated at least every six months
- diagnosis (where a patient is assessed for psychological therapy without involvement of a psychiatrist diagnosis, this must be entered by the therapist)
- Health of the Nation Outcome Scales (HoNOS)
- all correspondence.

Do patients know that they have electronic records? If not, then it is a breach of confidentiality to enter information onto the record without explicitly discussing this with patients. Whilst they are able to withhold consent for information to be uploaded onto the national spine, if they wish to receive treatment within a particular trust, they must consent to a medical record being held, and this is now an electronic record (which may be supplemented with a paper record for particular documents including those which require a signature).

### A psychoanalytic perspective

The psychoanalyst Christopher Bollas argues powerfully for the need to protect absolute confidentiality for the good of society<sup>6</sup>. However, he and another analyst, Allannah Furlong, both make a case that confidentiality can be expanded to be held by the profession of psychoanalysis. Furlong<sup>7</sup> argues that sharing information about patients in supervision is imperative for the good of the patient and for the integrity of the treatment to ensure that the analyst's comprehension and interpretive reach are optimised. She contrasts this treatment-oriented sharing with command disclosures with non-analytic aims which undermine the treatment. Her idea is that confidentiality should be thought of as a skin rather than a lock. Whilst both contain, a skin is a porous, dynamic, containing membrane that envelops the therapy, whereas a lock is a mechanical device impervious to the ambience of a relationship. She suggests that confidentiality should not be considered as an oath of non-disclosure but as a protective shield

for an analytic mode of listening. The ethical criterion for disclosure becomes: will it further the analytic listening and thus the treatment, or is it for unrelated purposes that may disrupt this listening?

Following the influence of the arguments made by Bollas, Furlong<sup>7</sup> reports that in 2001, the Canadian Psychoanalytic Society concluded that, contrary to what is sometimes implied, the aims of psychoanalytic and psychotherapeutic treatment do not conflict with society's interest in public safety. The impact of disclosure on the treatment situation, Furlong reports, depends on the reasons for the disclosure. When, for therapeutic reasons such as consultation/advice, professional secrecy is suspended, the disclosure will have only a beneficial effect on the therapeutic process. However, when this professional secrecy is lifted in the interests of a third party, the trust and security of the therapeutic relationship are undermined.

Furlong goes on to report: 'The value of disclosure in potentially dangerous situations has been greatly exaggerated in recent years. If an individual is dangerous, he is much less dangerous in treatment than without treatment. Too much emphasis on the need for disclosure for reasons of public safety may deter dangerous members of society from seeking treatment and frighten inexperienced psychotherapists into making unnecessary disclosures that will lead to the interruption or dilution of treatment. Both of these eventualities will increase, not decrease, the potential for antisocial behaviour.'

These conclusions about confidentiality are of relevance for us to consider in relation to the impact of electronic record-keeping. When is it the case that a therapist making an entry in an electronic record suspends professional secrecy for therapeutic reasons? Sharing information for supervision to overcome personal limits of understanding is very different from providing an entry on an electronic record for the purposes of ensuring compliance with trust policies regarding record-keeping and to ensure that a team functions safely and effectively.

The arguments for maintaining strict confidentiality in psychoanalysis

and therapy are persuasive, but within the NHS we are not only, or normally, working as analysts, but in a number of roles – assessors, consultants, psychologists, psychiatrists. When our role is as therapist we often do work very closely with other team members from our own or different disciplines with all the opportunities for splitting that go with this. The idea of confidentiality as a skin is a useful concept that can help guide our interventions. When should the skin stretch to encompass a supervisor, and when should it stretch to encompass other team members, or others beyond the immediate team who share care, and when should it stretch further to encompass referrers such as GPs?

### Case study

Mr T is an asylum seeker who had been an influential figure within a political party in his country of origin, and who had been arrested and tortured following a change of regime. He was clear that he did not want the details of his torture to be recorded in the notes.

He suffers from post-traumatic stress disorder with paranoid beliefs that his torturers will seek him out. Mr T hallucinates their faces and becomes dissociated with no conscious awareness of what happens during these episodes. He is fearful of interaction with others in case he becomes dissociated and attacks them. His marriage has broken down as a result of his symptoms, leaving him socially isolated. He has plans to return to his country of origin.

Whilst he has made some progress – with a decrease in suicidal ideation – progress has been very slow given his terror of his own violence. He has maintained a highly idealised view of his therapist.

Near the end of one therapy session he reported that he was carrying a knife for self-protection and that this was his normal routine. Following the session the therapist made an entry in the notes recording that Mr K had reported that he carries a knife. The

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therapist made a record because of the issue of risk and wanting to ensure there was a clear record but confident that this could be managed within the context of therapy. She did not consider that it was necessary to escalate to involve others at this stage.

Before he attended for his next therapy session, Mr T had an appointment with his psychiatrist who worked in the same trust and who had access to the progress notes held on the EPR. Having learned that Mr T carried a knife, she informed him that his action was illegal and that he must stop.

Mr T missed his next three therapy appointments and on returning to the fourth appointment, after the therapist wrote to him, his sense of having been betrayed by his therapist, and his rage at the betrayal, became evident. He was eventually able to report his anger and to explain that, if the therapist had not sent him the letter, he would have come and broken her consulting room windows.

According to what I have said earlier, this is not a breach of confidence in that, as a member of the team, confidentiality is maintained and held



within the trust. However, it was certainly not within the understanding of this patient that anything that he told his therapist could be seen by others within the trust. Instead we could think that the breach in confidentiality was seen as yet another intrusion.

Following his experience of being tortured (with violent intrusion into his body) he had lost his belief in the predictability of the world, and his belief in the protective function of his good objects had been shattered. The breach of trust by his therapist raised his anxiety with fears about the cruelty and strength of bad objects, prompting a slide into primitive paranoid beliefs that caused a rupture in the treatment.

This is one way of thinking about it. But might another be that the psychiatrist, who was also idealised by the patient as having saved his life, was in fact able to play an important role as the 'third', ensuring that the patient was unable to evade reality and acting as a valuable aid to the therapist?

## Conclusion

The use of electronic patient record systems does not entirely recast the clinical dilemmas that arise in the sharing of information with colleagues and beyond, but it certainly adds to the complexity of the issues concerned. In the clinical example there is evidence of an entry in the record being viewed differently by a colleague in the mental health system. This provides a platform for reviewing the utility of these records and the extent to which they can undermine the therapeutic process. It could also be argued that such disclosures are a necessary part of working to protect people from

harming themselves and others, as well as ensuring that our work in the consulting room does not become too removed from the wider team context and from truly multidisciplinary collaboration.

Do clinicians have a part to play in shaping these developments or are we merely swept along with the rising tide? Are EPRs simply a necessary evil, further evidence of the erosion of a valued therapeutic approach?

Both the authors are clinical psychologists and psychoanalysts. Their interest in this area leads to more specific questions: do psychoanalytically informed practitioners have more difficulty adapting to these developments than practitioners using other models? Might any scepticism or critical engagement on the part of psychodynamic practitioners simply be construed as evidence of an anachronistic approach out of step with this brave new world?

In contrast, we would argue that our abiding engagement and willingness to struggle with complexity, ambiguity, uncertainty and our understanding of the mind, puts us in a unique position to make a vital contribution. ■

*This article is based on a presentation given by Brian Rock and Helen Brindley, entitled Electronic Patient Records: the impact on the relationship with the patient, at a conference organised by the Tavistock and Portman NHS Foundation Trust, in March 2011.*

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## Reader response

The authors welcome questions and feedback about this article.

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“With the implementation of electronic record-keeping there has been a great deal of unease among therapists who are contractually required to make routine entries to update the patient record but who remain concerned about the implications of this in terms of privacy”







# Celebrating 25 years of 'transforming lives' in Southwark

The continuing success of the Southwark Primary Care Counselling and Psychotherapy Service is due to the counsellors themselves, and the ability to demonstrate their worth to commissioners and GPs, says **Peter Thomas**

**A**t a time when many were full of the doom and gloom about the introduction of the Improving Access to Psychological Therapies (IAPT) programme, the counsellors in Southwark decided to embark on a celebratory event to demonstrate their worth to commissioners and GPs. I am often asked why the Southwark Primary Care Counselling and Psychotherapy Service (PCCPS) is so effective and I am happy to tell people it is because of the counsellors themselves, who bring such a breadth and depth to the service, as well as a vast array of professional qualifications, life experience and learning through their own personal therapy and supervision. Compared to other psychological therapists, we are also extremely cost-effective.

A small working party combining the clinical counselling and psychotherapy lead and two of the counsellors got together with an empty piece of paper to think about ways that this celebration could be achieved. One of the greatest strengths of most counselling teams is their diversity and our group consisted of a rising comedian and a former actress. After much deliberation, the obvious solution emerged: hire a theatre, put on a comedy show and sell enough tickets so as not to make a loss, and while we had a captive audience, let the clinical lead loose to tell everyone how brilliant

our service is. So that is what we did and on a Sunday night in September 2010, we sold out the Southwark Playhouse theatre and celebrated our work over the previous 25 years.

Our event coincided with the publication of an independent review of the psychological therapies in the borough<sup>1</sup> to assess the psychological therapies and counselling services they currently commission in primary care with a specific focus on the extent to which the services are:

- accessible to people living in Southwark
- acceptable to and meet the needs of the diverse local population in an equitable manner
- National Institute for Health and Clinical Excellence (NICE) compliant (where possible)
- able to offer personalised care
- able to offer service user choice and demonstrate value for money.

The report had this to say:

*'The GPs we communicated with were strongly in favour of retaining the GP practice-based counsellors via the primary care counselling and psychotherapy services. Their experience of working with counsellors based within their practice was very positive. GPs like the primary care counselling and psychotherapy services and wanted us to be aware that in their opinion*

*it is working well and should continue on unchanged.*

*'In contrast, some of the GPs we interviewed were less positive about IAPT, citing problems around waiting times to access high intensity therapists. We do not support any cuts being made to the primary care counselling and psychotherapy services as we cannot see any evidence of service duplication which would not impact on the numbers of local people being able to access and being referred to this service. In addition, the support from local GPs for the primary care counselling and GPs who employ counsellors/therapists were described by many stakeholders as valuing and liking the service.'*

One GP stated: 'I very much wanted to say, as a practising GP, that the review should consider the strengths of the GP-based counselling model. I am concerned at the idea of centralising all services in one large referral centre... I would be grateful if you could feed back to the review my opinion that talking therapies should, by preference, be based in local general practices. This is by far the most patient-centred option.'

A second GP commented: 'We have always found counselling to be extremely useful and effective and we refer patients with a wide range of



conditions, ranging from stress, anxiety, bereavement, relationship problems, to patients with mild to moderate depression. We find that patients are happy with the service and that their symptoms improve and are even resolved in some cases with counselling. Many times, this is the only psychological support they will require. The attendance rate is good, the DNA rate low, and patients attend their sessions regularly. This will not be the case if the service is not based in the practice.'

Another stakeholder commented: 'I am an advocate of practice-based counselling as it removes the stigma that many patients associate with going to a mental health professional elsewhere. The counsellors have first-hand access to GP records and the patient's own GP, something that does not happen when located elsewhere.'

Many stakeholders said that the GP practice-based counsellors are linking up with other practice staff, such as care of the elderly coordinators and practice nurses, regarding referrals of older people for counselling. In terms of the extent to which the needs of younger people are being met, we found evidence of counsellors working within the primary care counselling and psychotherapy service practising flexibly with young people. In order to increase the attendance rates, young people are being offered drop-in appointments in recognition that some young people may, for a range of reasons, be unable to stick to a rigid appointment time.

One GP practice runs an art therapy group. This group has been a great help in identifying those who are depressed, vulnerable, lonely, or carers in need of support. One of its representatives stated: 'We very strongly wish that this invaluable service (practice-based counselling) be maintained long term.'

With regard to tendering out the current service, the report stated: 'It is unlikely that a new provider arrangement could match what is in existence. Whilst they may be able to offer a minimum cost service, the likelihood is that service outcomes could be badly affected. A considerable degree of risk is attached to this in as far as the degree of experience, skills and knowledge within the existing service providers in Southwark is very high.'

## History

In 1998, a small group of counsellors approached the chief executive of South Southwark Primary Care Group (PCG) to offer to help them develop the counselling services across the PCG. They received a warm welcome and this started a relationship which still exists 13 years later. This work consisted of producing a stocktake of counselling services, an options paper to be presented to the Board and costings to support the developments. The upshot was an extra £39,000 invested in GP counselling services and the counsellors coming together to form a counselling development group (CDG) which met monthly to develop ideas about how to move the service forward.

The CDG believed very strongly that its work should reflect the work that counsellors do in a congruent way and has always fought against a management structure being put in place. Instead they tried to encourage counsellors to work together and develop, and own, their work. This reflects the way we work with clients in encouraging them to own their journeys rather than tell them what journeys to take. Of course this makes for a more complex structure and relies on all the counsellors working together, a task that sometimes feels like trying to herd cats!

Developments so far include:

- a comprehensive mapping of counselling services
- a mapping of counsellors' qualifications and experience
- the development of a service specification
- writing a comprehensive counselling pack
- developing links with local universities, resulting in the placing of counselling students into practices, and the production of written guidelines for students, mentors, supervisors, the practices themselves and the university tutor lead
- yearly away days
- working with practices in the appointment and interviewing of counsellors
- supporting counsellors working in surgeries undergoing difficulties
- implementation of the CORE-OM audit and evaluation system



- liaising with third sector counselling providers
- working with counsellors to develop clinical governance best practice across all the surgeries
- introduction of continuing professional development (CPD)
- exploring best practices across the UK and how they can inform our own service
- producing a yearly statistical report of the counselling activity in the borough (see later)
- developing a counselling site on the Primary Care Trust (PCT) website
- creating a model of senior, junior, student and honorary counsellors within practices.

In 2003, when both north and south PCGs merged, the CDG was asked to work across the whole of the borough in the newly formed PCT. The team consisted of a clinical counselling lead and four counselling representatives who each liaised with one of the four localities.

The development group always took an interest in trying to demonstrate their effectiveness and worked with John Mellor-Clark to pilot CORE in the borough. The results of the CORE evaluation enabled the clinical lead to bid for extra money to develop the counselling service in new practices where counselling did not exist. The work was completed this year, with an extra £56,000 being invested, and Southwark now has a counselling service in all but two practices in the borough.

As clinical lead, I was asked to join the Southwark Psychological Therapies Committee to forge links with the secondary care mental health services, including psychology and psychotherapy. I am also a member of the PCT's Primary Care Subgroup, which reports to the Mental Health Partnership Board. The subgroup is tasked with developing primary care mental health and, more recently, IAPT. I meet regularly with primary care managers, mental health commissioners and the medical director of the PCT to advise on psychological therapies across the PCT. This has very much put counselling at the forefront of developing psychological therapies in Southwark rather than being a peripheral service. I am currently working closely with the IAPT service to

make sure that our service and theirs complement each other and that the counsellors and IAPT workers remain in close dialogue so that patients get to see the person who can best meet their needs. I also work with secondary services to make sure that the NICE guidelines are implemented across the borough, and maintain links with the third sector services in the borough.

“The link with GPs is paramount and reflects a concept that a primary care counsellor has an important role to play within a surgery rather than someone who just comes in to see patients and then goes home”

When most counselling services were changed into managed services and became part of mental health services, the CDG argued strongly to keep Southwark counsellors within primary care budgets and directly employed or self-employed by the practices themselves. This reflects a belief that the link with the GPs is paramount and reflects a concept that a primary care counsellor has an important role to play within a surgery rather than someone who just comes in to see patients and then goes home. The GPs take more ownership of the service and it can be adapted to the specific needs of their surgery rather than having a 'one fits all' model.

Over the years, more than 40 counsellors have served on the development group and given their time and energy to develop the service. Each person brings his or her unique contribution. As clinical lead, I also facilitate a free yearly awayday for all the counsellors which has proved very popular and helped the counsellors to feel less isolated. This year will be the 12th such day.

The clinical lead and representatives remain as self-employed consultants rather than as employees of the PCT, which enables them to keep the threefold focus of supporting the counsellors, working directly with practices, and working with the PCT to develop services. The role of the representatives is to liaise with the counsellors and pass information in a two-way process. At present we have 46 counsellors, plus honorary counsellors and students.

This integrated way of working has enabled counselling to be seen as an essential part of the services delivered to the patients of Southwark and also given a voice to a group of workers that sometimes feel excluded and undervalued. All this has been achieved through a bottom-up approach rather than a top-down approach, and the development group remains focused on developing the best service possible for the residents of one of the most deprived boroughs in the country. Frequently, students apply for junior posts after qualifying and over time can move on to more senior positions; some offer their skills as locality representatives on the counselling development group.

### Current role of the clinical lead for counselling

As clinical lead, my duties at present are as follows:

- to act as the professional counselling advisor within the PCT and advise the PCT on counselling policy and protocols, in conjunction with local, BACP and government initiatives such as NICE, clinical governance, National Mental Health Service Development (NMHSD) and national guidelines
- to assist the practices with the recruitment and employment of counsellors
- to link with third sector counselling services, GPs, mental health commissioners, South London and Maudsley NHS Foundation Trust (SLaM), and other health and social care professionals as necessary
- to facilitate yearly counsellor professional development days
- to maintain the professional profile of counselling with the PCT
- to produce the yearly statistical report and evaluation results





- to represent counselling on the Primary Care Mental Health Subgroup and the IAPT Steering Group
- to monitor and evaluate counselling resources
- to share with the individual practices to explore the differences in performance compared to the status quo
- to work closely with the director of IAPT in Southwark so that the two services do not duplicate services. An example of this collaboration was the director offering free training in both cognitive behavioural therapy (CBT) and mindfulness to primary care counsellors.

Below, I have included this year's front page of the report which gives the GPs and commissioners direct comparisons between the national IAPT service and our service<sup>2</sup>.

#### Executive summary

This report analyses the statistical returns completed by counsellors in 41 GP surgeries in Southwark for the year 2009/10. There were 44 part-time paid counsellors working for the service.

For the fourth time, CORE evaluation statistics are presented. Although coverage is not complete, initial findings show the service to be effective, with an average reduction in distress levels of 42 per cent when comparing outcomes to initial assessments.

We have data on 15,274 sessions offered over the year – although some practices have supplied returns for a full year. The cost per counselling hour is about £37. Eighty per cent of counselling hours are spent in direct patient care compared to 50 per cent of paid IAPT hours.

We have statistics on 3,334 people referred for counselling during the year, an increase of 15 per cent on 2008/09 figures (2,901 people). This increase is surprising, considering the introduction of the IAPT service.

Both anxiety and depression referrals fell by 24 per cent and 27 per cent respectively, demonstrating that the PCCPS\* service is NICE compliant and that the referrers are using the service effectively since the introduction of IAPT. It also shows that many patients in the borough seek psychological help for areas outside the remit of the IAPT

service which only sees people with a diagnosis of anxiety and/or depression.

The average number of days between referral and first offered appointment was 35 days, a small increase on 2008/9 (31 days). All except one practice have average waiting times within the NHS target of 90 days.

Seventy-six per cent of those referred are seen for at least an assessment. This is three per cent higher than last year and compares favourably with the 48 per cent reported by IAPT. This would suggest that people are much more likely to take up appointments offered in their practice surgery than those further afield. This demonstrates that 28 per cent more patients attend their primary care service assessments than IAPT assessments, which could be said to demonstrate that patients feel the primary care service is more likely to meet their needs than the IAPT CBT service.

Of those who had actual contact with a counsellor, 34 per cent had only one contact while 66 per cent went on to have two or more sessions. This presents a very different picture to the figures recently reported by IAPT for their users<sup>3</sup>. Here 70 per cent (of the 48 per cent who actually attended) had only one contact, with only 30 per cent going onto have two or more. It would be useful to know how many of the 64 per cent of patients referred to the IAPT service who do not engage with CBT finish up being seen by the primary care counselling service.

Patients seen by the service attended on average 4.2 sessions compared with an average of 1.5 sessions per patient reported by IAPT nationally. This demonstrates that patients are not only 28 per cent more likely to engage with the counselling service compared to IAPT, but once engaged are nearly three times more likely to continue with their treatment.

Twenty-six per cent of those discharged were referred on: this represents a four per cent increase on 2008/09.

The percentage of the total number of clients whose ages have been reported remains static although the actual total quantity measured has increased. There has been a further rise in the under-19 age group referred (1.69 per cent). The ethnicity of those seen for

counselling broadly continues to reflect the composition of the borough.

The statistics presented in this 2009/10 report present a very substantial body of work with an estimated 4,142 people being referred for counselling to in-house services, representing a 10 per cent increase on the previous year. About 80 per cent of those are seen at least once and of those, about 66 per cent go on to be seen for more sessions. The CORE-OM evaluation data suggest this work is very effective at reducing overall levels of distress, although there is considerable variance in the effectiveness evidenced between practices.

*\* Southwark Primary Care Counselling Service changed its name to include Psychotherapy on 1 April 2010.*

‘Special attention will inevitably be given to those remaining independent primary care services that not only survived the reorganisation, but also managed to generate new programmes for the future’

### The future

When the IAPT programme was introduced, its costs were initially ring-fenced. However, as of the 2011 tax year, IAPT has needed to be funded through mainstream budgets. From April 1 2011, in Southwark, the GP consortia have been responsible for the allocation of resources. However, at present, the consortia have to purchase IAPT, but have no obligation whatsoever to purchase primary care psychotherapy and counselling. For this reason, in many parts of the UK, primary care psychotherapy and counselling services have now been subsumed into IAPT. In this context, special attention will inevitably be given to those remaining independent primary care services that not only

survived the reorganisation, but also managed to generate new programmes for the future through the development of creative working relations with GPs and GP consortia.

At the moment in Southwark, there are 1,000 patients who are currently being seen by the community mental health teams that are being transferred back to primary care. Local hospital trusts are disinvesting in psychological therapies by making counsellors and psychotherapists redundant. This is likely to lead to a rise in presentations to GPs. In Southwark, we currently invest £2,800,000 in IAPT and £600,000 in primary care counselling.

So let us return to where we started. Martin Stanton, who was at the 25th celebratory event, comments: ‘The celebratory evening chose to highlight the creative ways in which the service has continuously engaged and worked with GPs and the local community to de-stigmatise mental health issues. In this vein, the theatre event told us in various ways that everyday “madness” was much more than an illness that confined people, but it should also be celebrated as oneiric and uplifting, no more so than through humour – a main focus of the celebration. Liz Bentley, well-known poet and comedian, as well as a senior therapist in the Southwark Service, showed us how mental health diagnoses can entrap and depress people, as well as inspire them to explore and enjoy their madness to the full. Crucial here is the central dialogue between GPs and counsellors/therapists around patients’ presenting and transforming “symptoms”, and their ongoing negotiation together of the management and care of such symptoms, including the outcome of medication and therapeutic treatment programmes. In Southwark, this dialogue has been both experimental and innovative, and supported by inter-professional groupwork, which has led to major mutual creative developments in GP-psychological therapy collaboration. In the brave new era of promised combined and collaborative treatment programmes in the NHS, this outstanding example from Southwark may well inspire new prototypes for mental healthcare in the quarter century to come.’

How many counsellors does it take to change a light bulb? Only one but it really has to want to change! I shall leave the last word with the GP consortia mental health lead, who recently stated: ‘The primary care counselling and psychotherapy services are bomb-proof.’ ■

*Peter Thomas MSc has been the clinical counselling lead at Southwark Primary Care Counselling and Psychotherapy Service for 13 years. Prior to this, he worked in the Gardens Practice in Southwark as senior counsellor for 23 years. Together with Liz and Ellie, he produced the 25-year event at the Southwark Playhouse. Peter also works for SLaM NHS Foundation Trust (a mental health trust) as a professional development facilitator, facilitating reflective practice and supervision groups for mental health teams, the arts therapy team and the chaplaincy. He maintains a supervisory and consultancy private practice.*

#### Acknowledgements

*Liz Bentley is touring her Arts Council-funded show Crash Bash Trash – Cognitive Behavioural Therapy – Can Box Tick/Can't Box Tick. Dates and venues can be found on her website [www.lizbentley.co.uk](http://www.lizbentley.co.uk)*

*Ellie Tremain is a counsellor at Villa St Practice in Southwark. She is also a part-time actress and has recently become a mother.*

*Martin Stanton is a freelance psychoanalyst and supervisor.*

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### Reader response

*HCPJ welcomes feedback on this article.*

*If you would like to contact Peter Thomas, or HCPJ, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)*

# A different way of thinking: understanding Asperger syndrome

**Maxine Aston** guides readers through the ability to recognise and work with this form of autism

If your client told you they thought they had Asperger syndrome (AS), how would you respond? Would you know what to say, what to ask, or what to do? Would you understand what that meant for your client, for their family, or how you could best work with and support them?

I have worked with individuals, couples and families where one or more are affected by AS for over 13 years. In that time, I have seen many changes as awareness of this complex syndrome grows. The importance of supporting the whole family is becoming a relevant concern to therapists and to health professionals generally. Yet despite the mass of information and books now available, I am still taken aback when I hear reports of damaging remarks made by professionals to clients with AS. For example, a middle-aged man was asked by a therapist, professing to work in the area of AS, how long he had been 'affected by this disease'. Perhaps more damaging is when a therapist, who disagrees with the idea of labelling, either does not inform the client that they may be on the spectrum or rebukes a client's request for AS validation. Either of these may well leave a client feeling that they are responsible for the difficulties affecting them and their relationships.

I often use the example of dyslexia by way of an analogy to AS, to explain the importance of knowledge and awareness. If a person has spent years struggling with reading and writing, impeding their confidence in their intellectual abilities, it can come as quite a revelation when dyslexia is recognised and diagnosed for them. They now have an explanation for their difficulties. In fact, they perhaps should be proud of how well they have managed despite dyslexia. It is a similar situation for someone with AS

when they become aware that their struggle with friendships, relationships, social interaction and communication is the result of being affected by something they can do little about; and that they are not outcasts, as many have reported being made to feel<sup>1</sup>.

Having AS does not change a person's personality. It is a neurological disorder, a difference in the wiring of the brain; not a defect, simply a difference. This difference often only becomes apparent when the AS individual interacts and communicates with others socially when looking to form friendships or relationships. AS will cause difficulties in communication (verbally and in the reading of body language), social interaction, and in the ability to empathise or to see things from another's point of view. Communication and empathy are key in forming and maintaining friendships and relationships and it is often within this area that the AS individual will struggle, causing feelings of inadequacy, isolation and loneliness; many find their confidence and self-esteem plummet. It is no wonder that a high incidence of depression has been found within this section of the population<sup>2</sup>.

Therapists are often the first port of call for AS individuals, their partners and/or family, making it crucial that they have the ability to recognise the possibility of AS, have knowledge of the effects of the condition, and have an understanding as to how they can best support the client.

## Tools for therapists

So what tools as a therapist do you need in your box? What do you need to know? The first stage is reading and gaining knowledge. There are many good books written on AS, both by professionals and those affected directly. A visit to the Jessica Kingsley website ([www.jkp.com](http://www.jkp.com)) will illustrate

just how many books have been written in the past decade alone that offer the reader an excellent selection of material. The book I most highly recommend is Tony Attwood's *Complete guide to Asperger syndrome*<sup>3</sup>, which covers all areas of AS and is packed full of readable information.

To work with difference, there needs to be an understanding of exactly what that difference is, and how this will affect the interaction between you and your client. To explain this both to my clients and professionals, I use an example of research carried out by Rita Carter, author of *Mapping the Mind*<sup>4</sup>, who wanted to discover how the brains of individuals with AS worked differently to individuals who were classed as neuro-typical (NT). The following is taken from my book *The Asperger Couple's Workbook*<sup>5</sup>.

*'Carter used Positron Emission Tomography (PET), a brain scanning technique that produces a three-dimensional, visual image of the functional processes of the brain. Carter used PET scans on people who had been diagnosed with Asperger syndrome and people who were not affected by Asperger syndrome. What she discovered was particularly enlightening, giving an insight into the differences in thought processing between the NT partner and the AS partner. First, Carter asked each group in the study a logical problem-solving question. Each group was able to come up with the answer by using logic and for each group an area in the left hemisphere of the frontal lobes lit up on the scan. Second, she asked each group a question that required theory of mind to answer the question correctly. Theory of mind is the ability to appreciate the perception of another, the part of*





*the brain that governs empathy and insight. Carter found that in the NT participants another part of the brain lit up on the scan. This area was just below the area of the brain that governed logic. The NT participants were quick to answer the question correctly. However, in the AS participants this part of their brain did not show any activity. Instead the logical part of the brain became active. This suggests that the AS participants were attempting to work out another's behaviour using logic, but people are not necessarily logical when it comes to behaviour. It is therefore likely that the AS participant's answer could be wrong (unless they had experienced a similar situation and were able to recall an appropriate answer). It will usually take them longer to find an answer as it will be through logic rather than empathy that they find it.\**

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‘Therapists are often the first port of call for AS individuals, their partners and/or family, making it crucial that they have the ability to recognise the possibility of AS, have knowledge of the effects of the condition, and have an understanding as to how they can best support the client’

These results imply that an AS individual is relying on the logical route in the brain rather than the empathic route to process information from others that, in many cases, is not logical. People often use double meanings, humour and innuendos in communication and non-verbal (body) language is responsible for the majority of the communication we share. Clients often say to me, ‘why is it that people cannot just say what they mean and mean what they say?’

AS individuals are non-verbal and mind reading is extremely difficult for

them to apply accurately; this can result in many misunderstandings in communication. When working with an AS individual, it is important to remember that in communication their brains will be working very hard to work out what you are implying; a client will not be able to read you non-verbally. To make communication less stressful for the client, you will need to be very clear, precise and talk in a logical way rather than using emotions. For example, asking the client the question ‘...and how did that make you feel?’ could create



if you cannot mind read then there is little point in making eye contact. The brains of AS individuals are already working hard just to keep up to speed in interactive communication; if they have to look at your eyes, or, with some people, even just look at you, they might not be able to concentrate on what they are saying or be able to accurately hear what you are saying.

### Communicating in the therapy room

I have learnt over the years not to try to read clients based on what I see and I will give them permission not to look at me. It is worth noting at this point that some AS individuals will make too much eye contact and this can feel aggressive or like flirting when in fact it is neither – often it

connect with their feelings would be like asking a severely dyslexic client to perform multiple spelling tests in the room. This could be damaging to the client and would certainly not be working towards maintaining the *BACP Ethical Framework*.

To work in a way that most benefits the AS client, it is important that the therapist adapts the session and communication to fit in with the Asperger world. Communication needs to be clear and logical; it cannot be expected that the client will suddenly acquire insight into what it is they are supposed to be doing; they will need clear instructions and logical options to consider. Counselling for AS clients should not be about trying to bring emotions to the surface; this could cause the client distress – they may

Asperger syndrome will cause difficulties in communication, body language, social interaction, and in the ability to empathise or to see things from another's point of view

anxiety in them as their logical brain attempts to define, discover and explain correctly the exact emotions inside them. Find out from the client how they best prefer to communicate; they may prefer to write things down or you could suggest they use another medium to express feelings. I have found with some clients that the use of colour to describe feelings and numbers out of 10 to express the intensity of the feeling<sup>6</sup> can be very successful. AS individuals are often great at visualising – seeing things drawn or written down will eliminate having to mind read and so reduce their stress.

Just as an AS client will have difficulty reading you, likewise, you cannot presume you are accurately reading them! For some AS individuals, making or maintaining eye contact can be very difficult; research studies of two-year-old children have shown that AS infants are more likely to study their mother's mouth than her eyes<sup>6</sup>. Non-AS people will look at another's eyes because they are reading the information the eyes are giving;

just means they have tuned out of their face and are no longer aware of the expression they are using, or have learnt to overcompensate. This is often a consequence of being teased at school over poor eye contact. You cannot read an AS person's feeling by their facial expression or body language, in fact, trying to draw a conclusion from a client's face could lead you to believe that they are not feeling anything at all. A client may not give any expressions or indicators as to what is going on inside emotionally for them and this has the potential to be falsely recognised as a cutting off from feelings due to trauma or childhood abuse. Although these areas may need to be investigated, this needs to be done with caution as it is more likely that a client is affected by a low emotional quotient or alexithymia.

Alexithymia is reported to affect 85 per cent of people with AS<sup>7</sup>. Alexithymia is a Greek word which simply means 'no words for feelings' and people affected by this condition may find describing their feelings almost impossible; being asked to do so or to

not be able to put those emotions into context and leave them behind when they leave the room.

It can be quite misleading if a therapist is working with an AS client and neither are aware that this is the case. The therapist may find themselves faced with a client who is unable to talk about their feelings and also has extremely vague memories of their childhood due to the late development of theory of mind. Put these two things together and childhood trauma and abuse may spring to mind, and it might be easy to find yourself off on the wrong track. Some clients who have come to me have found themselves involved in years of therapy, having become convinced that their difficulties are due to their childhood experiences. They are often left with feelings of anger and resentment, and when the true reason for their difficulties is discovered, they can then become even more resentful over the cost and the time they feel has been wasted in previous therapy sessions.

As a therapist you are not in a position to diagnose AS but you are in

a position to signpost – just to suggest the words Asperger syndrome can be enough. People with AS are often great researchers; if you give them the word they will go and look it up and make their own decisions on whether or not they believe this is a possibility. If they do want to explore this more, you will need to discuss with them the next step and highlight their choices. They may choose to seek an assessment or they may want to take time to read up and explore. What is important is that if they decide to continue working with you, you make them aware of the level of your understanding and what you are able to offer them.

### Being aware of sensory sensitivity

Another important area to be aware of and understand as a therapist is whether your client is affected by an over or under-sensitivity to sensory stimuli. These could be in the areas of sound, sight, touch, taste or smell. Checking that the environment in which you are working with a client is comfortable for them can make a difference to their level of stress. For example, I used to have a clock in my counselling room that had a noticeable, but not loud, tick. I moved it elsewhere after a couple of clients commented upon the ticking. Being distracted by noise can be detrimental to a client's concentration on what is being said – many AS clients report finding it almost impossible to hold a conversation in a place where there is background noise.

Further, when considering sensory sensitivity, a therapist needs to try and understand a client's level of sensory sensitivity, especially when working in the area of sexual therapy. Some clients with AS have reported being highly sensitive to being touched on specific parts of their bodies; this could be the arms or legs, or it might be the erogenous zones. If as a therapist you are using techniques such as sensate focus, understanding what feels good for your client needs to be very carefully explored and understood. It may simply be the type of touch used that causes the problem. One client explained to me that any form of light touching would make them feel like lashing out as it proved to be a source of total frustration and irritation.

Areas such as smell and taste are also crucial to check out. Some AS women I have worked with have expressed a strong aversion to their partner's bodily fluids; this can include kissing, ejaculation and oral sex. They can be physically repulsed by any possibility of exchange of fluids and their partners can be very hurt if this, as it can, causes retching or obvious signs of repulsion. Understanding that this is due to AS and not a personal issue can make a difference and help alleviate many hurt feelings. Understanding AS can make a profound difference to a client's intimate partner, as often they will be struggling to make sense of their relationship and wondering why the relationship is proving difficult to maintain.

### Understanding the impact on the family

In order to work with AS clients, you will need to have a clear understanding of both the client and of how AS will impact on their partner/family. Many non-AS partners report feeling emotionally deprived and can appear frustrated and angry over the relationship; they may have spent years trying to figure out what was wrong in the relationship. One non-AS partner discussed with me how she had been told by a therapist in couple counselling that her husband was just behaving like a man; this contributed to her decision to divorce as she felt their situation was hopeless and that no support was being offered. If you work with couples, by the time you see the non-AS partner, they may be feeling quite desperate to be heard or understood, and your validation of their feelings can be crucial to their wellbeing. In addition, if your client is unaware that it may be AS that is affecting the relationship, the ability to signpost could make the difference to whether or not the relationship survives.

Discovering what works best for your client can give them and you the best possible chance of having a stress-free and beneficial therapeutic alliance. If your client is comfortable and relaxed within the environment you are offering, if they feel you understand them and your acceptance of their difference is non-judgemental,

then you will be very privileged to experience the different, unique and special world of Asperger syndrome. ■

*Maxine Aston is a BACP-accredited counsellor and has an MSc in health psychology. She runs her own counselling centre where she specialises in working with individuals, couples and families affected by Asperger syndrome. Maxine also offers assessments for adults wishing to discover whether they are on the autistic spectrum, in particular whether they have AS. She is the author of three books, The other half of Asperger syndrome (National Autistic Society, 2001), Aspergers in love (Jessica Kingsley, 2003), and The Asperger couple's workbook (Jessica Kingsley, 2008). Maxine runs workshops to raise awareness in Asperger syndrome for counsellors and professionals who wish to increase their understanding and be able to offer their clients the support they need. [www.maxineaston.co.uk](http://www.maxineaston.co.uk)*

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### Reader response

HCPJ welcomes feedback on this article. If you would like to contact Maxine Aston, or HCPJ, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)



# Journeys in primary care

As a practice counsellor and local resident, **Ewan Davidson** walks through the same landscapes as his clients, resulting in a memory packed with intense, but fleeting, contact with other people's lives

I make maps. They've become more abstract over time, and at some point stopped involving paper and pens – perhaps once the need for constant revision got too great. But the basic idea remains.

Reading accounts of what I do as a counsellor always disappoints. The life gets squeezed out – and if we respect the condition that allows us access to colourful inner worlds, confidentiality, it needs to stay that way. I still feel the need to remember and try to represent the intensity and vitality of what I am part of. This must in some way be symbolic, and in a semi-rural area like mine, I find it easy to link these empathic traces to geography.

My map of my patch contained a lot of contours and some notes about good bird habitats and rock outcrops. Since I began to work at 'the doctors', it is now repeatedly embedded, overlain and eroded by traces of recounted experiences from other people's lives.

Clients' life stories rapidly overdetermined local landmarks – the top Pans, Woods, the queue at the Homeless, numerous cemeteries and shooting galleries, the Hopetoun Monument, the snug at the Pheasant. The healthy clean emblems of our burghs have been replaced by composites of feuding, fighting and f\*\*\*\*\* – and with signs of real health, fleeting aspirations reached, as it has always been for us, through thrownness and overcoming, conflict and crisis.

My service is currently trying to peddle a job description that describes my work as being with people whose resources have been overwhelmed. That would be a thankless task (albeit one which seems to keep a lot of health service managers busy) – instead, my work feels like finding the glint of resistance, and then letting go again.

The cost is that I walk through the same landscapes, the same Tesco, as my ex-clients, with the demeanour of one whose psychological contact was time-limited and has now expired.

And each of these relationships, however satisfactory and enabling, leaves a little scar, a little trace. And these condense into a memory packed to the extent that it dwarfs my 'real life'. Empathy, I think, leaves you feeling you've been there – it can leave you very drained and tired if you let it, and one of the ways it can do this is if you look at the whole of what you've done – open your card index, count and remember – faces and places, stories... novels... growing into libraries; even, how many times you've sat in that bloody chair.

I experienced some of this before in jobs in psychiatric care, but the opposite effect tended to happen. Patient X impacted on scores of health professionals on his journey to case-hood, and became a social glue between them. Here, as a practice counsellor, the experience of the client is unique to me, discreet and quickly

over. The sense of relating has grown steadily in me, but it only operates fleetingly. The client is usually in contact with me only to the extent that they are reassured that they can be in contact with their internal world.

I feel I am learning profound things about my world and myself (the experiences of others shape me – I grow through them as they affect me). They are not easily generalised, contained or summarised. The specifics burst out of any framework I know, like a bulging, picaresque novel – a novel I am (fortuitously) debarred from writing.

I feel connected to a lineage of sorts. Participant-observers, dominees, witches, elders, diarists, witnesses to life going on. I was doing this before I was a counsellor and I will be doing it well after I am replaced by a CBT computer programme.

It's been good to be encouraged by a salary (of sorts) and a professional description. It's been a relief to others. A particular historical moment sends you somewhere – 20 years ago a picket line, now a doctor's surgery. What one does to you allows you to do the other. When the going gets weird the weird turn pro, as Hunter S Thompson once noted, which I suspect will probably not be included in any future job spec, but is always a maxim of hope in interesting times. ■

*Ewan Davidson is a person-centred therapist working in GP practices in and around East Central Scotland. He has a long-standing interest in writing about the effects of experience on his world view, and this piece has grown out of his puzzlement at why that process has stalled since he became a counsellor.*

The cost is that I walk through the same landscapes, the same Tesco, as my ex-clients, with the demeanour of one whose psychological contact was time-limited and has now expired



## Reader response

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# GP viewpoint

What's not to like about outcome measures? asks **John Hague**

Love them or hate them, outcome measures are here to stay. It is absolutely normal practice in medicine to measure, for example, blood pressure and cholesterol, and it would be quite unthinkable to attempt to manage diabetes without knowing a patient's Glycosylated Haemoglobin.

Yet there is considerable resistance among many healthcare workers, including doctors, nurses and therapists, to regularly use outcome measures. Some of this is quite normal 'new concept denial', some represents insecurity at having one's ability examined, and some workers just feel that outcome measures 'get in the way' of the normal flow of a consultation or therapy session.

In Ipswich we have been regular users of outcome measures of anxiety and depression since 2005 – well before the Improving Access to Psychological Therapies (IAPT) programme came on the scene. All the practices in the town agreed to use the Australian Depression, Anxiety and Stress Scale (DASS-21). GPs and patients loved it. Patients felt that they were being taken seriously, and having their concerns validated, GPs liked the differentiation of anxiety and depression. We all found it useful to monitor a patient's response to treatment. Practices did not have to use the scale, but could claim extra payments for using it, along with other improvements in the care of patients with anxiety and depression. Everyone used it, and gradually came to value the clinical utility of the scale. One great benefit was that there were no copyright or costs associated with the scale, as it is in the public domain<sup>1</sup>.

The scheme was a forerunner of the Quality and Outcomes Framework, which now rewards primary care for using either the Hospital Anxiety and Depression Scale (HADS) (this costs slightly more than 60p per form to use)<sup>2</sup>, the Beck Depression Inventory II (this costs slightly more than £2 per form to use)<sup>3</sup>, or finally the PHQ-9. Of the three scales, the PHQ-9 is the

least expensive, being free at the point of use<sup>4</sup>, provided the user agrees to some simple licence conditions.

It will not surprise you to find that most practices have opted to use the PHQ-9! The PHQ Screeners website<sup>4</sup> also includes links to download the GAD-7 for anxiety, and the PHQ-15 for somatisation; also included is an interesting new measure, the PHQ-SADS, which combines measures for depression, anxiety, panic and somatisation.

It is quite reasonable for commissioners, and the public at large, to wish to know how many people have been treated, and also how many have benefited from services' interventions

At present many IAPT services, and GP practices, use a combination of the PHQ-9 and the GAD-7 as initial measures before referral. It would be of great benefit to try and increase use of the PHQ-SADS, as this will increase the profile and diagnosis of somatisation, and also increase conversations about panic attacks within consultations.

Other parts of mental health services are having to get used to using outcome measures, as HoNOS PBR (Health of the Nation Outcome Scale for Payment by Results) becomes more normal practice following work to introduce a tariff for mental health services. Initial resistance has been challenged by strong clinical leadership, leading to wider adoption, followed by acceptance and recognition of the value of the scales.

There is a value to measuring patient numbers, severity, and outcomes – it is quite reasonable for commissioners, and the public at large, to wish to know how many people have been treated, and also how many have benefited from services' interventions. In the future the payment that services receive will be based on these. In mental health we are unable to measure distant proxies, such as blood levels, or X-ray results, so we have no choice but to use patient reported outcome measures.

One of the great strengths of the IAPT programme has been the collection of the outcome data; we now have priceless data on the natural history of depression and the anxiety disorders which was simply not known before, along with real world data on the effectiveness of treatments, which has led to the confirmation of the effectiveness of counselling in depression.

So we have a change in practice that patients like, allows us to prove how good we are at getting them better, guides us when we might go wrong (by not spotting a deterioration, or the need for a step up), and in future will be the mechanism by which clinicians will be paid. What's not to like? ■

*Dr John Hague is a GP in Ipswich, and is a director of the Ipswich GP-led Commissioning Consortium.*

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- 3 <http://www.psychcorp.co.uk/Psychology/AdultMentalHealth/AdultMentalHealth/BeckdepressionInventory-II>
- 4 <http://www.phqscreeners.com/>

## Reader response

HCPJ welcomes feedback on this article. If you would like to contact the author, or HCPJ, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)

# ...outcome measures

There are, as Nic Streatfield points out in his article on page 4, 188 measures listed in the *Outcomes Compendium*<sup>1</sup>. The outcome measures listed here give only a taster of what is available, and have been chosen because of their widespread use in screening for and monitoring anxiety and depression in healthcare settings, or their usefulness to counselling and psychotherapy practitioners.

## BDI-II (Beck Depression Inventory)

The BDI-II<sup>2</sup> is a test for depression which measures the severity of depression symptoms in the American Psychiatric Association's DSM-IV<sup>3</sup>. It is not meant to be used to diagnose, but is an instrument to identify the presence and severity of depression and to detect and monitor changes in symptoms. There are 21 questions, with a total possible score of 63. Cut-off scores are given with the recommendation that thresholds be adjusted based on the client and purpose of use. The BDI has been used in some form for over 30 years – the original BDI was revised to BDI-II to bring it into line with DSM-IV criteria. It has been reported to be highly reliable regardless of the population, with the ability to differentiate depressed from non-depressed clients. There is also a 21-question anxiety measure, the Beck Anxiety Inventory (BAI)<sup>4</sup>. These outcome measures are not free, and need to be purchased before use.

## CORE-OM (Clinical Outcomes in Routine Evaluation Outcome Measure)

Extensively validated, the CORE-OM<sup>5</sup> is a 35-item questionnaire which measures a 'core' of clients' global distress, including subjective wellbeing, commonly experienced problems or symptoms, and life/social functioning. In addition, items on risk to self and others are included. The measure is part of the CORE system which also features the therapy assessment form and end of therapy form, the administration form, and the system user manual. Other products include shorter versions

of CORE-OM designed for repeated use, the CORE-LD for use with people with learning disabilities, and YP-CORE for use with young people aged 11 to 16 years. The system and its component parts are free to be photocopied under the terms of CORE copyright; a CORE system user manual can be purchased.

## GAD-7 (Patient Health Questionnaire)

A seven-item report measure used primarily as a screening tool/severity measure for generalised anxiety disorder (GAD), the GAD-7<sup>6</sup> forms part of the Minimum Data Set (MDS) for the Improving Access to Psychological Therapies (IAPT) programme<sup>7</sup>. Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further assessment is recommended when the score is 10 or greater. Evidence supports the GAD-7's reliability and validity in primary care, and it is also moderately good at screening three other common anxiety disorders – panic disorder, social anxiety disorder and post-traumatic stress disorder<sup>8</sup>.

## HADS (Hospital Anxiety and Depression Scale)

A screening instrument for measuring the presence and severity of anxiety and depression separately (a separate score is given for each). Cut-off points indicate whether a client is within the normal range, or in the mild, moderate or severe range. HADS<sup>9</sup> has been found to perform well in assessing the symptom severity and caseness of anxiety and depression in psychiatric and primary care patients and in the general population<sup>9</sup>. The use of HADS is licensed and a license agreement must be completed and a user fee paid before use.

## PHQ-9 (Patient health questionnaire)

A nine-item self-report scale which scores the DSM-IV criteria for major depressive disorder, the PHQ-9<sup>10</sup> also forms part of IAPT's MDS and is available

for use free of charge. The PHQ-9 has been well validated for diagnosing mental disorders in primary care in two large studies<sup>10</sup> (although clinical judgement is recommended for a diagnosis) and is also well-validated as a reliable measure of depression treatment outcomes<sup>11</sup>. Scores of 0–4 signal no depression, 5–9 mild, 10–14 moderately severe and 15–19 severe. Major Depressive Episode is suggested if either item 1 or 2 is marked as *More than half the days* or *Nearly every day*, or if five or more of the nine items are marked as, at least, *More than half the days* or *Nearly every day*.

## Shorter Psychotherapy and Counselling Evaluation (sPaCE)

An alternative, free-to-use symptom measure which is a shorter version of the PaCE-31 measure (developed to directly address change in shorter-term counselling and psychotherapy). Designed to screen for changes in anxiety and depression, sPaCE<sup>12</sup> can be used as a global symptom measure or by factor, of which there are six: general anxiety, phobic anxiety, functional cognitive problems, apathy, self-harm depression, and general depression. The two depression scales, together with functional cognitive problems and apathy, form a scale 'Depression Plus' that correlates with depression as measured by the BDI or PHQ-9<sup>13</sup>.

*And a new scale...*

## The Person-centred and Experiential Psychotherapy Scale (PCEPS)

A new scale denoting an attempt to operationalise person-centred/experiential counselling/psychotherapy in assessing treatment adherence/competence in randomised controlled trials (RCTs) and other forms of psychotherapy research. The PCEPS<sup>14</sup> is also intended as an aid to self-reflection and for use in supervision and training. The current version, which has undergone a reliability trial, consists of 15 items with two subscales – person-centred process, and experiential process. ■



# Employment matters...

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**Pat Seber**, consultant to BACP on workforce issues and service development, updates readers on her work, and answers some common work-related queries

It is some time since I updated you on my work for BACP. I have really enjoyed the opportunities, as well as the challenges, involved in helping members with employment and service issues; these range from information on TUPE (Transfer of Undertakings (Protection of Employment) Regulations 1981); self-employed and employed contracts; and – would you believe it – continuing Agenda for Change (A4C) issues.

Without doubt this is a very unsettling time for those employed or on self-employed contracts within the NHS, voluntary and private healthcare sectors. The changes proposed by the Government are causing concern to many and, at the time of writing, the Government is 'pausing' to reflect on feedback from nurses, GPs, research bodies, the unions and others.

Before sharing with you some of the queries sent in by members, I thought you would be interested in some of the issues raised at the 2011 Unison Health Conference which I attended in Liverpool in April. During the event, it was acknowledged that the NHS does need some reworking and not all proposals are bad. However the majority of healthcare workers are worried about the consequences to staff of the Government's proposed changes to the NHS.

Much of the discussion that took place would resonate with counsellors and psychotherapists. Although some individuals found that A4C did not meet their expectations,

the principle on which it is based: paying staff at a *nationally agreed level* (bands 1-9) for what they do, rather than the title they hold, is a good one. Currently, the Government is proposing that *individual employers* should set staff pay and terms and conditions of service. This is worrying as regionally negotiated contracts are rarely as good as the nationally agreed ones.

Over the next two years, the NHS is looking to make savings of over £20 billion. All trusts are to become foundation trusts by 2014 but already these organisations are being given 'freedoms' to make financial savings. Some of the proposed changes are aimed at the staff workforce: restrictions on sick pay (no pay for first three days), down-banding, freezing pay progression and not filling vacancies.

In addition, employers would be given greater responsibility for planning and developing the healthcare workforce. The emphasis here is on greater cooperation between professions and professionals to allow cross-fertilisation of ideas, skills and training, resulting in a greater 'skills mix' and new roles. We are told this will prepare the workforce to meet the healthcare needs of the local population.

No doubt there will be much more before we know the totality of the Government's NHS package. We will keep you up to date as much as possible but it would be good to hear from you about the changes in your area (see email at the end of the *Postbag* section, overleaf).

# Pat's postbag

Below are extracts from some of the most common workforce queries I have received; they are not from any one individual but compiled using an amalgam of questions on the same theme.

## Recruitment

*Query: I have recently applied for a post in an NHS trust. As I read through the job application, I meet all but one of the criteria which is, 'must have relevant NHS experience.' I believe this is discriminatory and wanted to know if employers are allowed to ask for experience in a particular environment.*

*Pat's reply:* I cannot be 100 per cent sure about this particular issue and so have approached NHS Careers, the UK Department of Business, Innovation and Skills (BIS), and the Advisory, Conciliation and Arbitration Service (ACAS); they all say go to your Strategic Health Authority with your query. I am going to try the Department of Health (DH) to see what they can offer.

*Reply from the DH:* I can appreciate the point you raise, but individual NHS organisations are responsible for the recruitment of their staff and must therefore decide on the wording of each job advertisement. The Department plays no role in the recruitment process. The NHS consults the NHS Employers organisation for advice on workforce issues. Information about NHS job specifications can be found on the NHS Employers website, although I should point out that advisers can only respond to specific queries from NHS employers themselves. The website address is: <http://www.nhsemployers.org>

*Pat:* Sorry this may not be what you wanted to hear but at least it is clear.

## Self-employed contracts

*Query: I have worked on a self-employed contract in a primary care trust (PCT) for about 10 years and have been given notice that the contract will end in six weeks' time with no indication of what service will be in place for clients. It looks like all self-employed contracts will end but there will be counselling jobs and I have been encouraged to apply. Is there any redress?*

*PS. I have since applied for one of the counselling jobs but was not successful.*

*Pat's reply:* Being self-employed can be both an advantage and a disadvantage and unfortunately on this occasion it seems to be the latter.

The main thing is to look at your contract and who paid you, GP or trust? Were you on a contract which was automatically renewed or did you get a revised contract annually stating a time limit to your 'self-employment'?

As it stands, self-employed practitioners have no automatic right to TUPE. I have contacted an expert on this matter and I am told that the key is in the wording of your contract, the length of continuous service and any changes made. Therefore I think if you could afford to pay for advice from an employment lawyer it could be to your advantage.

*Re: counselling interview* – did you ask for and receive feedback as to why you did not get a post with the trust?

I would be happy to talk this through with you if you think it might help.

## Supervision

*Query: My colleagues and I have been told that due to budget cuts we must give up our external supervision and be part of in-house arrangements. This means giving and receiving supervision from another trust. The problem is that none of our counsellors is a trained supervisor so we feel at a disadvantage.*

*Pat's reply:* This is an issue which is coming up in many parts of the country. External supervision does cost trusts thousands of pounds so they do look for ways of cutting the cost and in-house or reciprocal supervision is one answer.

There is no harm in the counsellors asking for a meeting with the manager to explain their concerns and if possible have some alternatives to offer. This shows that you have considered all sides of this problem, not only your own.

But beforehand, you and your colleagues need to think how you can compromise, because I'm sorry but that's what I think you are going to have to do.

Possible questions you could ask your manager: who in the other trust is going to provide the supervision? If they are not a qualified counselling supervisor (which your professional body would prefer but cannot insist upon) what does the individual know about counselling and the modality you work in? What happens if you feel that the appointed supervision does not meet your needs? As part of continuing professional development (CPD) and staff development, would your service pay for someone to undertake supervision training?

Discussions for counsellors: if management would pay for external supervision, could you agree on the same supervisor, or be willing to work in a group or in pairs? Could you ask the supervisor to meet with you on site to save in travel costs and time? Would one of you be willing to train as a supervisor?

## TUPE

*Query: I work for an organisation that has both employed and self-employed counsellors. Due to changes in counselling provision, a number of self-employed counsellors have effectively lost their work. Contracted employees have been offered employment under TUPE but they are experiencing great changes to their working environment (changes to banding, working conditions etc).*

*Pat's reply:*

### a. Self-employed

My suggestion here would be for your self-employed colleagues to pool resources to get advice from an employment lawyer. Much of what can and cannot be done depends on the actual contract. Some contracts that have been 'rolling' on for a long period of time may have more weight than others.

### b. Employees

My understanding of TUPE'd employees is that their job description, employment contract, terms and conditions of service, and salary band, including incremental rise, goes with them across to their new employer.

Obviously anyone starting with a new employer is going to expect differences between the old and new service but you should not be asked to do anything that is outside of your contract without consultation.

If you are working to a new contract, this should be up for negotiation.

However, services are allowed to make changes in certain circumstances under 'Operational Change' but this should be done with the consent and agreement of all parties, eg employers, employees and union representatives. (See [www.acas.org.uk](http://www.acas.org.uk) for details of a helpline service.)

*Update (April 2011):* Currently the unions are concerned that the new proposals to the NHS may negatively affect employee rights under TUPE.

c. If you were on A4C banding before, then it should continue. If you are not on A4C then I think you would need help in negotiating this with the new employers. They don't have to offer it and in some places (eg foundation trusts) are already trying to get rid of it.

d. Are you or any of your colleagues in a union such as Unison? If so then it may be helpful to get in touch and have a discussion outlining your concerns. If no one is in a union then it may be time to consider joining. There used to be a 13-week wait before they would offer any help but that no longer applies and you can get help almost immediately after joining.

## Down-banding

*Query: I am currently on an A4C Band 6 but my employer informs me that they do not have money to continue with my current post. If I would be willing to move to a Band 5, then it is possible for the post to continue.*

*Pat's reply:*

a. See [www.acas.org.uk](http://www.acas.org.uk). There is quite a large section on changing employee contracts which is what

your trust wants to do and it would seem that this is fraught with difficulty for the employer.

b. If the job is downgraded, what roles and responsibilities will you no longer perform? As I understand it, the employer must alter the job description so that you do not do the work of a Band 6 employee for the pay of a Band 5.

c. Is the claim that the choice is a job with a Band 5 salary or no job at all? If so, it seems as though your trust is going through major change and needs to save money. Have a look on the trust website – it is amazing how much you might discover this way. Usually union representatives have been involved in the decision-making process when trusts are going through organisational change – they may be able to shed some light on this.

d. If asked to a meeting to discuss this situation, take someone with you, as it is difficult to remember everything that is said when emotionally involved. Ask for things in writing so that both parties know what is being said; verbal agreements can be denied.

## To contact Pat

I hope this has given you an insight into what is happening to your colleagues across the country. Please contact me at [pat.seber@bacp.co.uk](mailto:pat.seber@bacp.co.uk) if I can be of help.

*Please note that Pat Seber can only offer suggestions and information to individuals for their consideration and does not claim to be an expert in employment law. BACP regrets that it is unable to go into the specifics of individual contracts.*

[pat.seber@bacp.co.uk](mailto:pat.seber@bacp.co.uk)



# On the receiving end

Maureen Downton's quest to find a cure for the physical effects of stress on her body led her on a journey through many types of therapy

I scarcely believed my doctor when, nearly 20 years ago, he told me that my shaky and rigid legs were caused by incorrect breathing. A community psychiatric nurse (CPN) I'd had contact with had also acquainted me with the physical effects of stress on the body. My anxiety had resulted from a stressful and bullying work environment; over the last few years, I have also suffered from panic attacks.

Over time, I have seen counsellors and tried alternative therapies in order to try to solve the problem. The first counsellor I saw – arranged through work – had a good professional manner and I found the six sessions very helpful; it felt good to be listened to and offload my concerns. I also gained some insight into myself and the dynamics of the office situation.

Another time, my doctor arranged some counselling for me – six sessions – but unfortunately this ended after four sessions due to the counsellor having an accident and I didn't feel I'd learnt anything.

I eventually left my stressful job but my anxiety continued. I read as much as I could about anxiety and this helped, but the condition continued to develop so that I no longer wanted to socialise; it was a great effort to go out unless I knew I could sit down immediately I arrived, making it difficult to stand in queues or wait for buses. I tried hypnotherapy but the therapist reminded me of a strict school teacher so I only went for two sessions.

After some years I decided to qualify as a counsellor; the training would be an asset in my job and hopefully allow me to gain more understanding of my anxiety problem. Personal counselling was a course requirement and I had the same counsellor for four years. It was wonderful to be really listened to and valued for who I was; I also valued the fact that everything was confidential. My self-confidence grew. We revisited the work trauma situation and did some inner child work. I grew

in understanding of the impact of childhood experiences. However, all this discussion and exploration made no impact on my rigid legs.

Occasionally, when I was feeling low and frustrated with the problem, I started to pursue other therapies. I tried hypnotherapy again which was a much better experience this time. The therapist was a good listener and I loved the deeply relaxed 'trance' state. We also did some visualisation, but after four sessions the therapist was unable to help me further. I also tried two other counsellors but did not feel comfortable with them as one seemed stressed and not very understanding and one was very passive, just smiling at me and offering very little feedback or observation. I tried craniosacral therapy – again, very relaxing but it had no effect on my legs. I also consulted a Jungian psychologist but terminated the counselling after six sessions as I felt she was disinterested. Thinking a body-based therapy would be helpful, I then tried the Feldenkrais method. The therapist was very professional and the therapy so relaxing, which provided mild but not lasting relief.

At that time, I was avidly reading everything I could find regarding anxiety and panic attacks using cognitive behavioural therapy (CBT) as a self-help tool. I discovered a psychologist who offered CBT. I had read lots about CBT and it had been covered in my counselling course, but I had never experienced it with a counsellor. There was immediate rapport between us and we worked through the *Mind over Mood* book<sup>1</sup>. I found it extremely useful to use the charts, along with the questions, in this book, to get a fix on how I functioned and my sense of reality. This counsellor was very supportive and my self-confidence increased, but I felt she lost interest when there was no change in my leg problem, her view being that the problem was caused by automatic thoughts. She recommended I see a

chiropractor and, again, this gave temporary physical relief, especially since by now not only were my legs tense and rigid, but also my lower back.

During this time I joined No Panic, a charitable organisation that supports people with anxiety disorders, and began to volunteer as a Help Liner. This has helped me enormously and I have realised, for the first time, the real importance of correct breathing, relaxation and exercise.

More recently, I began to read about bioenergetic analysis, a specific form of body psychotherapy, found a therapist and have now had about 15 sessions. Usually half of the hourly session is talking therapy and the remaining half is massage but I preferred at first to just have talking therapy. However, for the last two sessions we have included the massage, enabling me to release suppressed emotions. The therapist took a thorough case history from me and always seems to remember exactly what I've said. I feel she is dealing with my concerns at a much deeper level than I have ever experienced before with a therapist and I feel very much supported and understood. My body also feels much more relaxed and I am hopeful that, at last, I am getting to grips with my anxiety problem. ■

*Maureen Downton began her working life as a secretary before her interest in mental health led her to work for the charity Rethink. She later qualified as a counsellor and presently volunteers as a counsellor working with domestic violence and abuse, and as a Help Liner with No Panic.*

## Reference

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## Reader response

HCPJ welcomes feedback on this article. If you would like to contact Maureen Downton, or HCPJ, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)

# Just qualified...

The journey towards a paid counselling job is a long road, but I'm not giving up, says **Karen Barker**

When I began my journey on the counselling diploma, I was told it would change my life.

It certainly did, with a roller coaster journey towards understanding myself. However, I did not expect the next part of my journey – finding a job as a counsellor – to be quite as challenging.

It was halfway through my diploma that I began to realise that counselling jobs are very hard to come by, and that passing the course was just the beginning: I then had to go it alone without college support (although armed with my supervisor's support) to work towards accreditation.

After combining my study years with looking after my young family, due to changed family circumstances, there was a greater strain on my finding paid work once qualified. I had hoped to carry on volunteering as a counsellor until I found work, but due to my husband's redundancy, I found looking for *any* job was urgent. I was lucky enough to find a temporary job (which could become permanent) as an achievement mentor, a non-counselling role but a role for which a counselling qualification was stated as essential. When I first started my new job, I thought that perhaps using the counselling skills I had might be enough; but quickly began to feel it wasn't

enough for me to refer the students I was mentoring to counselling – I wanted to be the counsellor!

Due to my new working hours, I reluctantly stopped volunteering as a counsellor, but kept in touch with two of the agencies I had volunteered for, one a charity supporting parents or relatives of those affected by drugs or alcohol, the other a leading social care organisation (working in the drugs area).

Soon after starting in my new (non-counselling) role, I began to feel a great sense of frustration and loss. I realised I did not want to stop counselling. But I am caught between the need to have an income and wishing to continue counselling. Even though it is expensive to continue due to supervision, personal insurance and BACP membership, I still want to counsel.

In order to find work in counselling I registered on the NHS website so that suitable jobs are flagged up on my email. This saves me trailing through vacancy pages. There are difficulties: the vacancies coming up are asking for 450 hours and either accreditation or working towards accreditation. Both of these are problematic for me because I am struggling even to volunteer; I also need a part-time role in counselling due to my young family.

Last summer, before completing my diploma, I attended BACP's student conference and found the honesty of the speakers regarding finding work very helpful. The whole day was interesting and informative, and I approached a member of the BACP Healthcare Executive with my idea that the NHS could offer apprenticeships for qualified counsellors; this would give the opportunity to gain experience in healthcare if you are newly qualified.

During the conference, a key speaker told us his story of how he found work in a prison offering counselling to inmates. His message was 'don't give up', and he offered this quote by Joseph Campbell: 'Follow your bliss and don't be afraid, doors will be open where you did not know they were going to be'.

During training, I wrote in one of my assignments: 'I am halfway through this journey that has changed my life so much, but I am very happy to be able to help people in a skilled way, unlike in the past, when I wanted to help but didn't know what to do.' In hindsight, this still applies; counselling is in my blood, and if I could, I would be counselling tomorrow. Watch this space... ■

*Karen Barker qualified as a counsellor in June 2010. She has previously volunteered as a student counsellor at GASPED (Greater Awareness and Support for Parents Encountering Drugs) and the Sunflower Children's Centre, and since qualifying, has volunteered at Turning Point. She is currently looking for paid work as a counsellor.*

## Reference

1 Schwantes D. Ethics in a cocoon: how (not) to live well together. Indiana: AuthorHouse; 2007.

## Reader response

HCPJ welcomes feedback on this article. If you would like to contact Karen Barker, or HCPJ, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk)



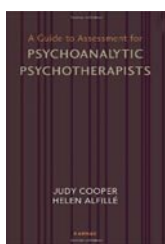
# Reviews

## A guide to assessment for psychoanalytic psychotherapists

Judy Cooper, Helen Alfillé

Karnac 2011

ISBN 978-1855755529 £9.99



In the preface to this book, Julian Lousada expresses concern at the lack of attention paid to assessment in the training of psychoanalytic psychotherapists.

I would certainly echo that. In defence of training schemes, perhaps some solid experience of work with patients is needed before one can confidently approach the sensitive and vital task of assessment. Nevertheless, though it can become the most rewarding aspect of work as a psychoanalytic psychotherapist, the task at first is daunting and sometimes overwhelming. Perhaps, therefore, thought should be given to the idea that ongoing training of psychotherapists could include careful consideration of this crucial aspect of the work as therapists grow into their role.

This bijou book (fewer than 50 pages) would certainly be a valuable companion to anyone seeking to take stock of their work in assessment. It is not detailed or systematic enough to serve as a comprehensive primer for trainees new to the task. But for those who have been laying up experience in the field of assessment and who would value a tool to help them pause, reflect on, and refine that experience, the book is a delight. And trainees would certainly get a taste of how central a part in a therapist's working life assessment can become. The authors clearly are experienced, sensitive, and wise therapists who are able to cast their thoughts on the assessment process in neat but extremely helpful ways.

There are chapters giving an overview of the whole process, consideration to the question of diagnosis, the structure

and nature of the assessment consultation, the issues of transference and countertransference, and contraindications for analytic work. But the book's chief value is perhaps in its peppering of clinical vignettes, often brief, yet all illuminating and helpful. In particular, the final examples of work with patients in their 60s, 70s and 80s are a most valuable counterweight to the ageism with which even Freud was so unfortunately prejudiced.

**David Quarmby**

Principal adult psychotherapist,  
Lancashire Care NHS Foundation Trust

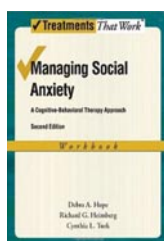
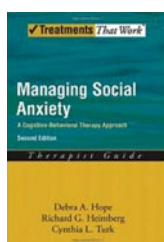
## Managing social anxiety: a cognitive behavioral therapy approach 2nd ed – therapist guide – workbook

Debra A Hope, Richard G Heimberg, Cynthia L Turk

Oxford University Press 2010

ISBN therapist guide: 978-0195336689 £27.50

ISBN workbook: 978-0195336696 £17.99



From a therapist perspective, these books should be seen as a pair rather than as single books. They are part of the Treatments That Work (TTW) series and people familiar with the style of the series will find the structure and format reassuringly familiar. Readers unfamiliar with the series can check out

resources at: [www.oup.com/us/ttw](http://www.oup.com/us/ttw)

These books form one of the problem-specific treatment protocols which underpin much of the Improving Access to Psychological Therapies (IAPT) model. As such, they are essential reading for therapists and supervisors providing cognitive behavioural therapy (CBT)

interventions within psychological therapy services.

The books have been significantly updated from the first edition (published in 2000), both in relation to the evidence base but also in relation to elements of the treatment techniques. There is a very strong clinical narrative throughout and the changes demonstrate that the authors have used their clinical experience to shape the content while grounding the book in a very solid research base.

The clinically collaborative underpinnings of these books are evident from the first chapter of the client workbook which is entitled, 'An invitation: are you ready to begin the journey to overcome social anxiety?' This acknowledgement that there are pros and cons to addressing social anxiety and the incorporation of a decisional balance exercise as part of the planning process with the client show that the authors are as focused on the collaborative relationship as on the clinical techniques.

The psycho-education and assessment sections are very strong, as are the background chapters at the beginning of the *Therapist Guide*. This will provide therapists with a strong theoretical basis which provides the framework on which the therapy for social anxiety is delivered.

Therapists who are newer to working with social anxiety will find the session-by-session structure helpful in laying out a treatment path with clients. More experienced therapists can use the structure to review their current practice and ask the 'why don't I do it this way?' question.

These books will provide therapists with a sound theoretical underpinning, guidance on how to structure and deliver social anxiety treatment in conjunction with clients, and a perspective on troubleshooting problems that arise in the course of treatment.

**Kieran Doherty**

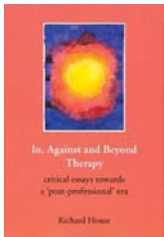
IAPT lead/senior practitioner, Inclusion Matters primary care psychological service, Liverpool



## In, against and beyond therapy: critical essays towards a post-professional era

Richard House

PCCS Books 2010  
ISBN 978-1906254322 £22.00



This book has been published at a crucial time when the teaching and practice of counselling and psychotherapy are being questioned not only by practitioners

but also by the Government and, more widely, the State. As such, Richard House's critical essays on what a 'post-professional' era really means directly conflict with the current drive towards qualification, research and theory to support evidence-based practice. This book challenges the very basis upon which the Improving Access to Psychological Therapies (IAPT) programme and Layard's

*Depression Report*<sup>1</sup> are founded.

*In, against and beyond therapy* skilfully critically analyses literature that spans over two decades, focusing on postmodern themes that question the very foundations of psychotherapeutic practice. House highlights the tensions between rigid systems founded on post-enlightenment scientific 'truths' that have emerged from positivistic theory construction versus a postmodern deconstruction that leads to psychotherapy based on the paradox of 'knowing the unknowing'. He presents literature that emerges beyond the age of scientific Cartesian dualism, questioning psychiatric diagnosis to consider how acceptance of unexplainable subjective experience informs spirituality. Interestingly, House also discusses ideas of the development of spiritualised cognitive therapy.

House analyses the literature of leading postmodernist writers to develop a stance in relation to psychotherapeutic ethics, professionalisation, training, and proposes a way forward in a transmodern post-therapy era. He challenges the reader to think beyond the post-

enlightenment and modernist paradigm to consider postmodernist thinking in the context of the professionalisation of psychotherapy.

This book is an interesting read for practitioners and trainers alike and poses some very difficult questions relating to what exactly is taking place within the counselling room. Once the power and knowledge is deconstructed, the basic premise is that power, knowledge and evidence-based practices are constricted regurgitations of power bases that miss the essence of humans' 'being'. House concludes by offering an alternative view of what counselling in a transmodern era might look like.

### Margaret E Smith

Senior lecturer and programme leader for MSc Integrative Counselling and Psychotherapy, University of Derby; integrative psychotherapist

### Reference

1 The Centre for Economic Performance's Mental Health Policy Group. The depression report. A new deal for depression and anxiety disorders. London: LSE; 2006.

# Web resources... ...Asperger syndrome

### [www.aspergerfoundation.org.uk](http://www.aspergerfoundation.org.uk)

Website of the Asperger's Syndrome Foundation, a small charity committed to promoting awareness. Includes information sheets and details of training for parents and professionals.

### [www.autismni.org](http://www.autismni.org)

Northern Ireland's autism charity website has a downloadable booklet for mental health professionals. *Waking up to Asperger's syndrome* aims to raise awareness of AS as a mental health issue, and provides basic information on diagnosis and treatment options.

### [www.autism.org.uk](http://www.autism.org.uk)

The National Autistic Society's useful website includes an introduction to AS and details of services, news and events.

### [www.mencap.org.uk](http://www.mencap.org.uk)

Features a downloadable factsheet on AS and an excellent professionals' area with information on aspects affecting people with a learning disability.

### [www.ninds.nih.gov](http://www.ninds.nih.gov)

AS information page prepared by the National Institute of Neurological Disorders and Stroke (NINDS).

### [www.scottishautism.org](http://www.scottishautism.org)

Publications on autism, including helpful reading suggestions.

### [www.talkaboutautism.org.uk](http://www.talkaboutautism.org.uk)

Online community for parents and carers of children with any form of autism; helpful site with clear instructions on how to join in.

### [www.users.dircon.co.uk/~cns](http://www.users.dircon.co.uk/~cns)

Plain but informative site for

university students with autism and AS; includes books/articles, study skills, and surviving the university environment.

### [www.wrongplanet.net](http://www.wrongplanet.net)

Wrong Planet is a web community designed for individuals (and parents/professionals of those) with autism, AS, ADHD etc, where members communicate with each other. There's an article section with how-to guides, a blogging feature, and a chat room for real-time communication.

Please note that AS is commonly referred to interchangeably as either Asperger's syndrome or Asperger syndrome.



# BACP Healthcare update

## Chair's report

### **Tina Campbell outlines the news from the division's Executive**

The summer has finally arrived – even in Scotland! In stark contrast to my last update, the snow on the hills has been replaced by a wonderful covering of purple heather. I reminded myself recently how often I take these beautiful scenes for granted, because they are always there, yet constantly changing.

In the world of therapy, change is what we are about and yet we do so in the context of holding consistent therapeutic boundaries with our clients. It can sometimes be too easy to take things for granted, including the constancy and safety of the therapeutic relationship and the tremendous courage and resilience we meet every day in our clients.

A couple of months ago, while driving south along the M1 and passing the exit for Bretton Hall, I was reminded of travelling to my own counselling

training at the University of Leeds. Those journeys (which I am sure will resonate with others!) held many emotions but the overriding one was of excitement, reflecting an enthusiasm for all that learning and a deep desire to want to be a good therapist. I am privileged to be reminded of that each day when I see the enthusiasm and excitement in our students on trainee placements. It is that enthusiasm which reminds me that there is much to look forward to, even when as a profession we travel through uncertain times.

### **Come and meet us**

As an executive, we have been busy pursuing our decision to have a Four Nations approach and do our best to meet with members. It is important that we hear directly about the issues affecting you as therapists in 2011. So far we have managed to arrange informal gatherings with members when we attended 'Making Connections' events in both Belfast and Edinburgh. It was good to meet with so many

members, and we look forward to meeting more at future events.

Can I draw your attention to the 'Making Connections' section of the BACP website ([www.bacp.co.uk/making-connections/](http://www.bacp.co.uk/making-connections/)) where you can register for these free events. They offer an excellent mix of networking opportunities and information gathering, and always have an interesting keynote speaker.

### **Upcoming BACP Healthcare events**

In the autumn, BACP Healthcare will host a seminar in York on the subject of 'Healthcare in transition: strengthening our professional identity'. The one-day event aims to bring you up to date on relevant developments and reforms in healthcare. You'll find further details about how to register interest on page 4.

Later in the year, we plan to hold a conference in Scotland which will offer a particularly northern perspective... more information to follow.

As always, do get in touch! Please email me at [tina.campbell@bacp.co.uk](mailto:tina.campbell@bacp.co.uk)

## Development update

### **A new research project on GP commissioning is among the initiatives taking place at BACP, writes Louise Robinson, Healthcare development manager**

#### **Healthcare reforms and GP commissioning**

I write this update after the coalition Government has announced a 'natural break in the passage' of the Health and Social Care Bill (affecting NHS England) to enable further consultation<sup>1</sup>. This news has been broadly welcomed and affords us all some time to reflect on the proposed reforms and prepare for changes ahead.

It also seems to me that the 'natural

break' allows more time for the GP consortia that are ploughing ahead with local reform to work through the pitfalls and offer central government some of the solutions. I think these pioneering GP consortia will be in a strong position to influence the finer detail of reforms and their implementation.

In this evolutionary context, BACP is leading a research project that aims to inform how we engage with GP commissioning in order to support improvements in counselling provision. As I write, the research project is in process, and includes interviews, focus groups and surveys of GPs, commissioners, practice managers, BACP members and key individuals from other interested

organisations. To all those who are reading this and have taken part – thank you!

I intend to deliver a workshop on GP commissioning, which will be informed by our current research, at the divisional conference (for more information, please see the back cover). I am planning an interactive session and look forward to working with delegates on the day to develop our joint understanding and capability to engage and influence GP commissioning.

I am keeping an open mind on the findings of the research but I anticipate that the success of BACP's future work to influence improvements in the provision of NHS counselling across the UK will be enhanced by

the engagement of BACP members as local ambassadors. I am keen to hear from any members interested in the work we are doing and in working together to influence change. Email me at [louise.robinson@bacp.co.uk](mailto:louise.robinson@bacp.co.uk) or tel 01455 883311.

### Counselling for depression

In follow-up to the article *IAPT and counselling – the story so far* in April's issue of *HCPJ*, I thought it may interest *HCPJ* readers to know that BACP has completed the first wave of post-qualification training in Counselling for Depression (CfD) to 72 trainees. The training takes a manualised approach to helping clients address the emotional problems underlying their depression and is delivered through 10 half-day teaching modules which include: generic induction to IAPT, theoretical principles and values, humanistic conceptualisation of depression, application of core conditions in the context of IAPT, working with emotional process, and working briefly. The modules are designed to ensure the training is compliant with recommendations in the National Institute for Health and Clinical Excellence (NICE) guideline for depression.

‘I anticipate that the success of BACP’s future work to influence improvements in the provision of NHS counselling across the UK will be enhanced by the engagement of BACP members as local ambassadors. I am keen to hear from any members interested in the work we are doing and in working together to influence change’

The training to date has been funded by the Department of Health; BACP plans to deliver another wave of CfD and CfD Supervisor training in collaboration with higher education institutions in the academic year 2012. BACP is also considering how to widen access to the training for counsellors who are not funded by IAPT but who are interested in gaining this qualification. Entry requirements for the training are:

- Diploma in humanistic/person-centred counselling or psychotherapy
- Minimum two years post-qualification experience (healthcare setting)
- BACP accreditation or equivalent.

BACP-accredited counsellors who successfully complete the training and subsequent 80-hour practice period can apply for a Senior Accreditation award. Non-accredited BACP members can count the training towards their BACP accreditation training and practice hours.

More information will follow in future updates; in the meantime, if you have a query about the training please email [healthcare@bacp.co.uk](mailto:healthcare@bacp.co.uk)

### Reference

- 1 Watt N, Wintour P. NHS reforms: Lansley agrees to change health bill. <http://www.guardian.co.uk>; 4 April 2011.

## Reader response

### Response to Isabel Gibbard

I read Isabel Gibbard's Opinion page (*HCPJ* April 2011) with interest and would like to add my own comments to the debate on Counselling for Depression (CfD). Firstly, I think BACP is to be commended on its efforts to initiate person-centred therapy into the Improving Access to Psychological Therapies (IAPT) programme. Introducing a specifically designed person-centred/emotion-focused therapy (EFT) focus for working with depression is a welcome challenge to the prevailing and relatively unquestioned trend for cognitive behavioural therapy (CBT) and I feel BACP is to be further applauded

for its commitment to developing a randomised controlled trial (RCT) of counselling for depression<sup>1</sup>.

Though I agree with Isabel in that I too understood that counselling is a generic term and the title therefore is somewhat misleading, risking obscuring the person-centred modality, I understand that BACP informants have emphasised that the use of the term 'counselling' in this way is purely pragmatic, but would encourage speed in moving towards the proposed use of 'person-centred experiential counselling for depression' for this intervention<sup>1</sup>.

My main concern, however, is how the extensive entry criteria to be



accepted onto the training for CfD, which clearly designates this training as post-qualifying training, will be perceived by the Department of Health, and consequently NHS staff and general practitioners. The current entry requirements are: a diploma in humanistic/person-centred counselling



or psychotherapy, a minimum of two years' post-qualification experience (in a healthcare setting), BACP accreditation or equivalent, and experience/qualification in supervision<sup>2</sup>. The training then requires an additional 80 hours of supervised practice with fortnightly supervision before a therapist (who it should be stated is already qualified and accredited) is considered competent enough to work with depression within the NHS and IAPT. Presented with this information, and comparing this with CBT therapists, who are seen as qualified to work with depression as soon as they have completed their training and without the need to be accredited, I worry that most will draw the conclusion that qualifying as a person-centred practitioner is not sufficient enough to work in the NHS and with depression. I wait with bated breath to view any entry criteria for humanistic practitioners to train to work with anxiety.

As a trainer on a BACP-accredited postgraduate diploma course in counselling and psychotherapy (person-centred), I would welcome the opportunity to include training for CfD on the course, enabling students to prove their competency to work with depression in IAPT. However, the entry criteria dictate that therapists have to be qualified, accredited and indeed supervising, before they can be considered sufficiently experienced to train. This is especially frustrating as, by the end of the course, successful students will have already met both the general therapeutic competencies and the metacompetencies for CfD and are familiar with EFT, which is taught on the programme. Including training for CfD in established BACP-accredited person-centred programmes would also rapidly increase the number

of therapists trained in CfD, which would help in offsetting the identified low numbers of CfD practitioners in the development of a RCT of CfD. I remain puzzled and concerned that such a great opportunity for including humanistic therapy in IAPT has been restricted in this way.

*Angela West (MBACP Snr Accredited counsellor and Accredited supervisor) is programme leader for the Postgraduate Diploma in Counselling and Psychotherapy at Liverpool John Moores University.*

#### References

- 1 Cooper M. Development of a randomised controlled trial for counselling for depression. BACP; 2011. See [http://www.bacp.co.uk/admin/structure/files/pdf/7123\\_development%20of%20a%20rct%20of%20counselling%20for%20depression.pdf](http://www.bacp.co.uk/admin/structure/files/pdf/7123_development%20of%20a%20rct%20of%20counselling%20for%20depression.pdf)
- 2 Hill A. Curriculum for counselling for depression: continuing professional development for qualified therapists delivering high intensity interventions. IAPT; 2011. See: <http://www.iapt.nhs.uk/silo/files/curriculum-for-counselling-for-depression.pdf>

#### Current thinking on anxiety

I would like to thank *HCPJ* for the cluster of articles in the January 2011 edition. I can't remember the last time a series of articles sparked my thinking as much as these, particularly the article on intensive short-term dynamic psychotherapy (ISTDP) and the piece on experiential psychotherapy and the vagus nerves. So much information was packed into this series of articles but in a very digestible form, helping me crystallise my thinking in such a massively complicated and important area.

Reading about current thinking on the physiological basis of anxiety; anxiety and early attachment; and about the technique of focusing, and reflecting on all the issues raised in these articles, is already contributing to a shift in my practice. For example, working more explicitly than I did before with clients' 'felt sense' of problems and being explicit with them about why I am offering to work with them in this way, seems to be paying dividends, judging by feedback I am getting from my clients to date.

Congratulations *HCPJ* on such an interesting and useful edition!

*Cordelia Galgut, CPsychol, MBACP (Snr Accred); counsellor/psychotherapist in private practice*



### Reader response... ...we invite your views and experiences

*HCPJ* welcomes feedback about any article, column or news item in this issue. If you'd like to contact any of the authors, or the editor, please email [hcpj.editorial@bacp.co.uk](mailto:hcpj.editorial@bacp.co.uk), or write to the address on the inside front cover, marking it clearly for the attention of Sarah Hovington, Editor, *HCPJ*.

We also welcome ideas for articles relating to counselling and psychotherapy within the healthcare sector. We are particularly interested in new perspectives on current thinking, debate on practical or professional issues, and sharing of knowledge, experience and practice. For information on how to submit an idea, please contact the editor, details as above.