



CPD profile: Mid-career Clinical Psychologist

1.1 Full Name: Mid-career clinical psychologist

1.2 Profession: Clinical Psychologist

1.3 Registration Number:

2. Summary of recent work/practice

I gained my doctorate in clinical psychology twelve years ago and have worked in several different settings, but in the last two years I have been based in Working Age Mental Health Services. I offer specialist secondary services to adult patients (18-65) who are referred through Community Mental Health Teams (CMHTs). This includes psychometric assessments, other forms of assessments (using interviews and structured observations) and the planning and delivery of psychological therapies. The main psychotherapeutic models I use are Cognitive Behaviour Therapy (CBT), Cognitive Analytic Therapy (CAT) and systemic therapy. I have particular interests in working with clients with eating disorders, or who deliberately self-harm, or who experience recurrent depression.

As well as my direct patient care, I offer consultation and case management advice to colleagues within the CMHTs. I also supervise two less experienced psychologists and one counsellor, and I usually have a trainee clinical psychologist on placement with me. I run teaching sessions for community psychiatric nurses (CPNs), social workers and other members of CMHTs and I regularly teach on local training schemes for both clinical psychologists and High Intensity workers on the Improving Access to Psychological Therapies (IAPT) programme.

I am involved in several projects at Trust level: for example I am a member of the Work Well-Being Strategy group which is investigating the levels of work stress and work satisfaction among Trust staff. We have been tasked to draw up a set of recommendations to improve the well-being of our workforce. I am also frequently asked to offer mediation in situations where conflict between members of staff is compromising their capacity to work together effectively for the benefit of our clients.

I am an active member of my professional society, the British Psychological Society (BPS), and sit on one of the committees concerned with guiding ethical behaviour.

Total Words: 297
(Max. words: 500)

3. Personal Statement

Standard 1: A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.

I use the BPS on-line CPD recording system which helps me plan my CPD on an annual basis and keep note of the important points of my learning from undertaking the various activities. I update my CPD log monthly. I attach my CPD logs covering the past two years (supporting evidence item number 1).

Standard 2: A registrant must identify that their CPD activities are a mixture of learning activities relevant to current or future practice.

I have kept up with the professional literature through reading books and journals, particularly focussing on books or articles concerning the use of psychological interventions for adult clients with chronic and severe problems and on those concerned with supervising other practitioners.

I have regularly received individual supervision (monthly) from a consultant clinical psychologist, where we discuss all aspects of my work. I meet with a group of peers (monthly) to discuss our CAT cases, and attend quarterly meetings of a “systemic practice interest group”. Further details of all these activities are given in the attached BPS CPD logs.

My manager is not a clinical psychologist but as part of our monthly management meetings we use the NHS Knowledge and Skills Framework (KSF) programme to evaluate my work, and once a year we write a Personal Development Plan (PDP) which specifies areas in which I will undertake CPD, taking into account both my own areas of particular interest and the needs of the service in which I work. A copy of my most recent PDP is attached (supporting evidence item number 2).

I attended one general conference (four days) and three specific workshops (1x 1 day, 2x 2 day). Certificates of attendance are attached (supporting evidence item number 3).

Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.

Standard 4: A registrant must seek to ensure that their CPD benefits the service user.

Example one: Keeping up with the literature and using it to the benefit of service users and colleagues

CBT is a wide and evolving discipline and I have expanded my understanding of the “third wave” of cognitive therapies through reading books and articles (supporting evidence item number 4) about Mindfulness-Based Cognitive Therapy (MBCT). One of the books that I read was the seminal text *Mindfulness-based cognitive therapy for depression: a new approach for preventing relapse* (2002) by Segal, Williams and Teasdale. Many of the new theoretical concepts are relevant to my practice, particularly those concerned with problematic depression and the psychological mechanisms which may lead to relapse.

Older cognitive theories have not really paid much attention to the relapsing nature of severe depression and so in my contact with clients I did not spend much time discussing this with them. Both my clinical work and my teaching and consultation to other health professionals have changed to take account of these new developments in theory and practice. For example, service users have benefitted from me spending more time on relapse prevention work with them than I did previously. Next year I would like to attend some training events on MBCT and perhaps introduce it into our service, perhaps setting up MBCT groups for clients.

This year I have read about supervision models and method. I have found particularly useful *Evidence based clinical supervision* by Derek Milne (2009) and *Supervising the reflective practitioner* by Joyce Scaife (2010). I have spent time in my own supervision discussing my experience of being a supervisor and thinking about my development in this area. I have put this learning into practice this year to benefit my supervisees. I did have a situation this year when a supervisee experienced adverse life events which resulted in severe anxiety and depression. I was keen to support my supervisee yet worried that their capacity to offer adequate care to their patients was badly compromised by their own psychological situation. I received conflicting advice from various managers and supervisors to whom I took my dilemma. I did eventually suggest to my supervisee that they needed to take time away from work, and the supervisee agreed. The experience raised for me the need for further training for me on the subject of fitness to practice, and the role of the supervisor in assessing this (supporting evidence item number 5).

Example two: Attending workshops and using the knowledge gained to benefit service users.

A workshop I attended this year was on “third wave” cognitive therapies, Acceptance and Commitment Therapy (ACT) called *ACT for clients with eating Disorders*. I initially felt sceptical that it could produce lasting improvements for people who are struggling with chronic and severe physical and mental health difficulties. In my normal practice I see people for up to 30 sessions of 50 minutes each. This workshop suggested that a session might last two hours or longer, but that only one to three widely-spaced sessions are offered. The workshop encouraged me to experiment more with my professional practice and to question some of my assumptions about how interventions ought to be delivered. Since attending the workshop and doing more reading I have incorporated some of the ideas in ACT into my normal work. This has made me keen to take the next step, and use the full ACT model for at least a few clients, to compare its efficacy with our treatment as usual. I will need first to find someone with the time and competence to offer me specialist supervision in this new work.

Attending the ACT workshop has had positive benefits for the clients that I work with who have eating disorders, to meet standard 4. This is a client group I have specialised in for several years, and I found the workshop very illuminating as it helped me to think in a new way about clients. I feel my work with this client group has become deeper and more subtle. I have more ways to help me understand and communicate that understanding, and more ideas to suggest that might help my clients to move forward in their lives. For example, with one client who experienced bulimia I was able to help her ‘ride the waves’ of emotional provocative thoughts and impulses that linked to her cycle of binge eating and purging.

Example three: Having supervision and developing supervision skills to benefit colleagues and through them service users

Much of my work is indirect, supporting other staff to develop their own clinical skills, and in this sense the clinicians I supervise and teach are the users of the services I provide. In our quarterly meeting of the Systemic practice interest group (SPIG) (supporting evidence 6) we discuss theoretical issues as well as presenting our own cases for discussion. I presented one of my complex clinical cases where our team discussions concerning this case were full of tense conflict and bitterness. Through the questions, comments and feedback from my SPIG colleagues I began to understand the parallels between the family situation in which these clients had grown up (and where they still lived) and the professional situation in which we were trying to offer them care. The competition for parental attention, the rivalries and jealousies when one appeared to need or deserve or simply to be offered a “better” or “worse” kind of attention than the other, the stifling mixture of guilt and fear and the tensions between belonging and feeling like an outsider – these were all clearly powerful shaping forces in the client’s family, and we as a team seemed to have repeated all of these dilemmas in the way we discussed what we were doing, and what we should be doing.

Following this discussion I was able to suggest different ideas to my team, so that we became much clearer in what we offered to the clients as individuals, but we also offered family sessions in which we could explicitly discuss the difficulties of separation, differentiation, autonomy and relatedness. In situations such as this colleague can be considered service users as they are directly or indirectly affected by my practice.

Example 4: Learning from technology to benefit colleagues and through them service users

I regularly teach unqualified, pre-qualified and qualified staff and I try to keep my teaching up-to-date through my own CPD. I recently had some training in the use of PowerPoint and have begun to use this routinely in my teaching (supporting evidence item number 7& 8). I now am able to produce handouts of my slides and I have been surprised at how welcomed these have been. The format does demand verbal succinctness and visual simplicity, and perhaps this is what appeals. This has produced hand-outs that are more accessible and easier for colleagues to understand because the presentation is clearer than my previous hand-outs. This has included hand-outs that can be used directly with service users.

Word count 1489 (maximum 1500)

4. Summary of supporting evidence submitted

Item number	Description	Format and amount	CPD standard number
1	BPS electronic CPD logs covering past two years	Paper copies: 4 pages for this year, 4 pages for last year	1, 2 & 4
2	Current PDP	Paper copy: 3 pages	2, 3 & 4
3	Certificates of attendance at the conference A, and workshops B,C and D	Paper copies: 4 sheets	2 & 3
4	Copy of article on third wave CBT Piet, J., Hougaard, E. (2011). The Effect of Mindfulness-Based Cognitive Therapy for Prevention of Relapse in Recurrent Major Depressive Disorder: a Systematic Review and Meta-Analysis. Clinical Psychology Review, 31 (6), 1032–1040.	Paper copy 8 pages	3,4
5	Evaluation of my supervision by clinical psychology trainee	Paper copy, 2 sheets	3,4
6	Notes from Systemic Practice Interest Group	Paper copies 10 sheets	3,4
7	Evaluation forms following my teaching to IAPT High Intensity trainees	Paper copies, 15 sheets	3,4
8	Hand-outs of PowerPoint slides I used in two different teaching sessions	Paper copies, one of 10 pages, one of six.	3,4