The British Psychological Society

hcpc health & care professions council

CPD sample profile

1.1 Full name: Counselling Psychologist – early career

1.2 Profession: Counselling Psychologist

1.3 Registration number: PYLxxxxx

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2. Summary of recent work experience/practice.

I have worked for two years in adult mental health in a secondary care National Health Service (NHS) outpatient psychology service. I provide psychological therapy for adults with mental health problems who are referred by their general practitioner (GP) and other medical professionals. I work with a range of mental health problems including depression, anxiety, obsessive compulsive disorder, generalised anxiety disorder, phobias, post traumatic stress disorder and social anxiety.

I provide specialist psychological assessment using a semi-structured interview and self report measures such as the Patient Health Questionnaire PHQ9, Generalised Anxiety Disorder GAD7, Beck Depression Inventory and Beck Anxiety Inventory. I draw upon different models to explain mental health difficulties and find the biopsychosocial model particularly useful in understanding what might be contributory factors to the presenting issue such as depression. The main model of therapy that I use in my clinical work is the cognitive model as introduced by Beck in the 1970s and developed by leading clinicians over the last 30 years e.g. the Oxford Cognitive Therapy Centre and Beck Institute for Cognitive Therapy and Research, and evidence based research. I assess clients for suitability for psychological therapy and for the type of therapy most appropriate for their psychological needs. I undertake risk assessment and management following the Trust protocols. I keep up to date electronic records of my client contact on Patient Case Management Information System PCMIS and the electronic patient records system RiO. I provide assessment reports to the referrer.

I present assessments at the psychology therapies team meeting and following discussions with the team we make recommendations for therapy choice. This includes making onward referrals to other specialist services such as drugs and alcohol. I communicate sensitively the outcome of assessments to the client and referrer.

I manage a personal caseload. I work collaboratively with clients to develop psychological formulations of presenting problems; emotional, cognitive and behavioural. I develop plans for individual psychological therapy within a brief

therapy model of up to 20 sessions. Typically, I offer between eight to twelve sessions of therapy.

I contribute to evaluation and continued development of psychology provision. This includes auditing referral pathways and collecting data on client satisfaction (evidence 8). I provide a consultation service on clients' psychological care to non-psychologist colleagues in general practice and community care teams.

I provide supervision to primary care mental health workers. I receive regular clinical professional supervision from a more senior psychologist.

I am a member of the British Psychological Society (BPS) and within the Society the Division of Counselling Psychology, and the British Association for Behavioural and Cognitive Psychotherapies.

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3. Personal Statement

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

I have updated my knowledge and skills over the past two years since qualifying by undertaking a variety of learning activities that contribute to the quality of my clinical and professional practice. I engage in a process of supervised reflection with a more senior psychologist and this enables me to identify my ongoing development needs. As a practitioner I have a personally reflective sense of my professional development and look at development from the inside out in the form of my journal.

I use the BPS online system to record and monitor my CPD activities in a more formal way. I update my log on a monthly basis and include reflections in my journal. This log has a list of all different types of learning activities and these are linked to my current and future practice.

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

My learning needs have been identified through my annual appraisal and personal development plan with my line manager. I also identify my CPD needs through informal discussions with colleagues. My current learning needs are focused on enhancing care for clients with recurrent depression as the majority of clients on my case load have been referred for depression. In view of this, one of my objectives was to develop my knowledge of and skills in third wave Cognitive Behavioural Therapy (CBT) especially mindfulness. The other main objective for this two year period was to develop my supervision skills and the learning activities I attended are detailed in my CPD record. This covers what I learned, how this learning affected how I work and

how the learning benefited service users/quality of work. The ability and skills to manage risk is pertinent in my service as depression is a risk factor in cases of suicide. I have volunteered to be on the working party for risk management as this will improve the service protocols and ultimately the service we provide to clients.

My learning activities range from the formal to the informal, and are focussed on enhancing my clinical and professional practice. The activities that I have undertaken include workshops, journal club, supervision, delivering workshops to non-psychologist colleagues and reading research literature.

As a member of the Division of Counselling Psychology (DCoP) I receive the Counselling Psychology Review, this way I remain up-to-date on current issues, developments, and key players in the field. I specialise in cognitive behavioural therapy (CBT) and receive the Behavioural and Cognitive Psychotherapy journal. This journal contains research and clinical reports that inform my practice. These readings also have informed my professional practice such as developing supervision skills. I found Werner. M Pretorious. (2006). Cognitive Behavioural Therapy Supervision: Recommended Practice. *Behavioural and Cognitive Psychotherapy*, Vol 34, pp 413-420, useful as this covers what is recommended as good quality CBT supervision. I have been able to compare my own practice, when supervising primary care mental health workers, with these standards. I found the generic supervision competences suggested by Roth, A. D and Pilling, S. (2007). 'Competency Framework for the Supervision of Psychological Therapies' useful in informing my practice.

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.

The examples below demonstrate how my CPD activity has contributed to my clinical practice and, the client and service delivery. The activities show how I have developed a deeper understanding of the theories and models that I apply in my clinical work.
For example:

Self-directed learning on recurrent depression (evidence 3 and 4)

A substantial number of clients that are referred for therapy suffer from recurrent depression. I read some of the research literature on the proposed psychological processes that maintain recurrent depression. I used this knowledge to formulate the client's experience within the framework of the CBT model for depression. I share this knowledge with clients and they have found it helpful in aiding their own understanding of what keeps their depressive episodes recurring. I have found that my clinical practice supports the research in that ruminative brooding (Watkins, E. (2004). Adaptive and

maladaptive ruminative self-focus during emotional processing, (*Behaviour Research and Therapy*, (42), 1037–1052) and avoidance are two of the main mechanisms that keep depression symptoms going in the present.

I enhanced my learning about depressive rumination (evidence 4) as this is a core pathological process in depression that clients frequently describe in my clinical practice. I was influenced in my work by Watkins, E., Scott, J., Wingrove, J., Rimes, K., Bathurst, N., Steiner, H., et al. (2007). Rumination-focused CBT for residual depression: A case series. *Behaviour Research and Therapy (45) 2144-2154*. This research suggests, based on preliminary evidence, that rumination- focused CBT may be efficacious for residual depression. I shared this with clients and asked that they kept a rumination record sheet of the situations that triggered rumination, how they felt, what they were thinking about and what were the consequences of this. It was through this process of self monitoring that clients began to notice how often and how long they ruminated. They were able to identify typical situations that triggered rumination and to come up with a plan as to how they were going to interrupt this process. Clients found it challenging to change their habitual way of responding to problems. However over time they learnt the skills needed to change. They reported in their relapse prevention plans that they found this technique helpful in reducing low mood.

Training on mindfulness (evidence 5)

The above work lead me to seek out, read and digest journal articles regarding what is known as 'third wave CBT', specifically mindfulness based CBT (Teasdale, J. D., Segal, Z. V., Ridgeway, J. M. G., Soulsby, V., and Lau, M. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 615-623) is one of the therapeutic approaches utilised to manage recurrrent depression.

To find out more about the mindfulness approach I participated in an eight-week mindfulness stress reduction group programme. I found this a challenging experience as during the course I was required to meditate for 45 minutes for six days a week. This experience enabled me to develop a regular mindfulness practice. I have continued to develop my mindfulness practice by attending retreats for personal and teacher training purposes. This has improved my clinical practice as it has enabled me to increase my own reflexivity when working with clients by being more attuned to small changes in their feelings, bodily changes and thoughts that occur in sessions. It has increased my awareness of how difficult it can be to pay attention in the present moment to your own experience.

One aspect of the training course that we learnt about and practised is the 'three minute breathing space' in which you stop and notice what is going on in the moment and then redirect your attention to your breathing. Following this you expand your attention to your whole body and the space around it. One of the aims of this is to notice where your attention is and what brings you back to your breathing if your mind wanders. This has benefited my

clients as I have used this in sessions as a taster for whether they may find this mindfulness approach helpful. I have found the clients with recurrent depression who are judging and self-critical report that they find the three minute breathing space helpful in that they have noticed how often they are judging themselves harshly. They report that they have come to realise that this approach exacerbates their depression symptoms. I have been able to refer these clients on to the eight week mindfulness course.

Workshop (evidence 6)

I attended a workshop at the British Association for Behavioural and Cognitive Psychotherapies annual conference on ' Using enhanced reliving to work directly with trauma memories associated with Post-Traumatic Stress Disorder (PTSD)' by Deborah Lee and Kerry Young. This provided practical guidance on how to explain the rationale for reliving and how to do reliving. This benefited the service user as I was able to improve the quality of my practice by using the 'brain explanation' rationale with a female client that held a strong belief that her PTSD symptoms were her fault and that she should be over this by now. She found the rationale that the hippocampus and amygdala were not working together due to the traumatic incident as helpful as it meant for her that how she had responded was not her fault. She had the motivation to complete the reliving based on this explanation and her PTSD symptoms as measured on the Impact of Event scale reduced to a non clinical level. This particular rationale made sense to her as she worked in the scientific field where factual evidence was important in making decisions about the best way forward.

Peer Review (evidence 7)

I attend a fortnightly peer review group in which I present complex cases. This enables me to discuss interventions and outcomes with colleagues. I find this experience invaluable as it directly informs my practice. For example, one of the clients that I was seeing did not want any information about our sessions communicated to his GP. We explored the meaning of this request for the client in the context of his mental health issues. It also resulted in a debate about confidentiality and what was in the best interests of the client. As a group we held different views and decided to seek further advice from the Trusts solicitors on this case to ensure that we were up-to-date with current legislation and case law. I learnt that the patient had a right not to have any information disclosed to his GP without his consent unless there was significant risk of harm to self or other. The client did not have the right to have his psychology record destroyed. I learnt that the minimum retention period for these records was 20 years as detailed in the Records Management: NHS Code of Practice Part 2 (2008). This knowledge has contributed to service delivery as all psychologists gained a more in-depth understanding of the application of both local and national confidentiality and records management policies. This was of benefit of the client as there is a record of the treatment course in the psychology department for continuity of care should they present for therapy in the future.

4. Summary of supporting evidence submitted

Evidence Number	Brief description of the evidence	No. of pages	CPD standards that this evidence relates to
1	Record of CPD activities over the last 2 year period	4 pages Hard Copy	Standard 1
2	Personal development plan and appraisal	3 pages Electronic CD	Standards 2, 3 and 4
3	Review of literature on depression- maintenance processes	2 pages Electronic CD	Standards 2, 3 and 4
4	Notes from journal reading on ruminative response style	5 pages Hard Copy	Standards 2,3 and 4
5	Certificate of attendance for Mindfulness Programme and reflective journal	1 page Electronic CD	Standards 2,3 and 4.
6	Certificates of attendance at BABCP workshop and conference	3 pages Hard Copy	Standards 2, 3 and 4
7	Peer review reflections	3 pages Hard Copy	Standards 2, 3 and 4
8	Example of an anonymised client satisfaction questionnaire	3 pages Hard Copy	Standards 2, 3 and 4