Personal best

Ian Florance talks to **Victor Thompson** about working in sports and clinical psychology

The increase in sports participation in England isn't reaching government targets, yet over seven million people meet the target of three 30-minute sessions of moderate intensity sport three times a week, and huge numbers of people watch sport. It's obvious that sport plays a big role in many people's lives, including Dr Victor Thompson's. The description on his website of how he competed in the 2006 Ironman Switzerland competition made me want a little lie down: a 2.4-mile swim, a 112-mile bike ride, followed by a marathon. Victor finished the race, but came round to find himself in an intensive care unit on a ventilator.

Victor's route to psychology and triathlons started in East Belfast. 'I did a BTEC course in psychology and found the social and applied psychology modules particularly interesting.' It's perhaps a clichéd question to ask, but did his environment affect his interest in psychology? 'I'm sure it did, particularly in social and group psychology. There were obvious divisions in society, and schools could be tribal; you had to be careful where you hung out. I knew people who were directly affected by the Troubles. I worked in the YMCA on community youth clubs and outreach projects.' Given Victor's later specialisation, was he interested in sports at school? 'Not really. I went to a very authoritarian school and I didn't like the way they organised sport or academic life. The school emphasised rugby, and as I was smaller than average, I just didn't like getting crushed by the other players on cold, wet winter days. I preferred more individual pursuits, like cycling, to team games. The sporting world is incredibly diverse, and I chose the activities – outside school mainly – that fitted me best.'

Victor studied psychology at the University of Sheffield. 'Although I knew no one when I arrived in Sheffield, I really enjoyed the course. I think it's good for any student to pursue what they enjoy. Qualifying to practise psychology is a long and arduous road, and you need that genuine interest to maintain motivation for the long run.'

Did you immediately want to study sports psychology? 'I was involved in a lot of sports and worked in US summer camps, so the interest in people and what made them tick was there. But sports psychology was even more of a niche area than it is now. It was my dream job, but at that time it was no more than that as I couldn't see how I'd manage to have an interesting job doing it and manage to pay the rent. Clinical psychology seemed sexy and attractive – what everyone seemed to be pursuing – and very competitive. Yet it also seemed to be a lottery to get into, with very similarly talented and experienced graduates competing for a limited number of places. I wasn't sure I wanted to go down that route. But I was absolutely sure I wanted to do something practical not just academic.'

So it seems strange that his first job was as a research assistant. 'Following on from my degree I was keen to get some, or any, kind of hands-on experience in a clinical or research field that would help me explore the potential of clinical psychology. I was fortunate enough to gain some initial experience with Professor Glenys Parry, the then Head of the Clinical Psychology Service in Sheffield and the first psychologist to work on mental health policy with the Department of Health. But her present job, Professor of Applied Psychological Therapies at Sheffield, gives the clue to why I found the work so rewarding. Glenys is very talented and very down-to-earth. For three years I continued to gain more and more relevant clinical and research experience for clinical psychology. I worked with adults, children, in regular mental health settings, drugs and alcohol, sexual health and chronic pain. For the last fifteen months of this I worked in the R&D Department, again with Glenys, supporting any member of staff involved in doing or using research. This

reinforced the fact that it was working with people that was rewarding, not working on abstract ideas in some isolated lab.'

During this period Victor started to compete in triathlons and took a diploma in sports psychology. 'But I still wasn't sure that was the right route for me. At the time sports psychology didn't seem to be a profession that offered a variety of jobs outside academia. It hadn't reached the stage it has now, where sports psychologists work with teams and individuals.'

In 1998 he went to UCL to study clinical psychology. 'It was still a lottery to get into and Plan B was to pursue research opportunities while I formed my sports psychology – or other – plans further. But I got on the course and enjoyed it hugely: it pushed me professionally and personally. Clinical training gives you a generalist skills set: you learn basic techniques, knowledge and approaches that you can apply to different populations. You're given the opportunity to work with many different sorts of people and I particularly enjoyed working in primary care and hospital-based clinical health psychology. I was intrigued by health issues that lead to psychological difficulties for some people, or how pre-existing psychological difficulties or styles then affect their physical health condition.'

After his clinical course, Victor travelled widely and describes his Australian stay as among the most memorable experiences of his life. 'I met an Aboriginal artist and watched him paint a scene from his homeland. Then a few days later I was invited to spend Christmas on the beach with him and his family. I watched his sister paint for 14 hours straight on Boxing Day, creating one work. This now hangs on my wall as a special memento. Travelling can open us up to experiences with very different communities and ways of living. But essentially, we are all the same and can have a lot of common ground if you are only open enough to find it.'

When he came back Victor needed a job in clinical psychology to consolidate his training and to pay off the travel debt, but: 'I also wanted to learn to approach sports psychology in a way that fitted for me. At the time it seemed to me it didn't always deliver down-to-earth, but effective interventions based on science and practical experience. There was lots of information around about how to improve your performance but less about how to apply it in a straightforward but believable way. I'd been doing triathlons for six years so I had a good experiential base for developing my own skills, understanding clients and rethinking the discipline.'

Is there an element of 'Physician heal thyself' in Victor's own sporting activities? He laughs. 'Not really. As you've seen, triathlon is very taxing, but I'm not frenetic or addicted to it. I don't have the need, as some people do, to exercise obsessively. Which is a very good example of how I view psychology's – all psychology's – contribution to sport and exercise. Exercise addiction or obsessiveness is there for a reason. So, you need to start from that viewpoint and ask "What keeps the habit going, caused it to develop in the first place and what might help to change it?". Psychologists help people to think about their thinking, motives and behaviour, then to experiment with doing things differently.'

Victor picked up where he left off at the end of training in clinical psychology. 'I took up a permanent position which I still hold. I work four days a week in a primary care psychology service, which

FEATURED JOB

Job Title: Head of Assessment and Selection (and other Consultants and Associates)
Employer: Alexander Mann Solutions

'The Head of Assessment and Selection role is an ideal job for a psychologist with a solid assessment background and business development experience, who wants to develop expertise across the entire employee life cycle,' says Tony Hall, Global Head of Talent Management at Alexander Mann Solutions (AMS).

The organisation was founded in 1996 and now employs 1500 people in 60 countries. 'Although the foundation of our business is in the resourcing space, increasingly our clients need to integrate HR services in order to drive innovation and efficiency,' says Tony Hall. 'That need creates new opportunities for us across the talent management agenda.'

'Within that broad framework of talent management, we're expanding our work to areas such as executive assessment, performance management, executive coaching, succession planning and the like. We're looking for a person to lead the team who can grow all of those areas, together with consultants and associates who are more rounded.'

> "our clients need to integrate HR services in order to drive innovation"

The Head will have at least an MSc in psychology and will be eligible for chartership if not necessarily chartered, Hall says. 'They'll not only have the in-depth knowledge that goes with the qualifications, they'll have significant experience delivering services, managing other psychologists – all of the team have MScs – and in market development. Aside from that typical experience, we need someone with imagination and vision to take advantage of the opportunities offered by our services and client base.'

Do you develop your own assessments? 'We develop our own tools, but also use instruments from a range of different test publishers. Where I think we have distinctive expertise in the team is in the creative design of assessment processes and tools that are integrated with the client's brand. Along with our award-winning resourcing communications team, we put together assessment solutions that are robust but also conscious of the brand and the candidate's experience of the brand.

Where do you think applicants will come from? 'We'd expect some from big consultancies and maybe the testing industry. But some might well come from internal consultant positions within large blue chips. In fact, if you have the right attitude, skills and desire to expand your experience across the life cycle, where you are now matters little. The key thing is that there's a huge amount to do. The two qualities we're looking for – from both the Head of the Service and Consultants/ Associates – are energy and imagination.'

You can find this job on p.617, and with many others on www.psychapp.co.uk. The site provides a valuable resource to Society members and employers alike.

leaves one day, some evenings and weekend time to work in sport. I have consulting rooms, but I do a lot of my work over the phone. This is obviously unusual since most psychology is done in face-to-face sessions over a moderate to extended period. But a motivated athlete, or an amateur juggling a job and sport, rarely has much spare time in their busy schedule. Elite athletes can be training or competing abroad. That you can achieve something concrete while fitting in with their priorities is an initial test of whether they want to use you. I probably don't ever see a third of my clients, and many of my consultations are carried out over only two or three phone calls. For instance, I might do a phone consultation with a rider who has fallen off her horse. The horse just won't trust its master who is nervous and tense. The horse senses that something is wrong. That issue has been addressed by phone. I prefer to meet people in person; but if that's impossible, the telephone can work effectively too.'

Are the two jobs – in primary care and in sports psychology – very different? 'Yes and no. I'm trying to help people in both. Both require me to use many of the same skills and knowledge to address different problems. Both are about performance – whether you are overcoming setbacks in sport or setbacks in your personal life – and as a consequence improving confidence, mood and enjoyment. We should never forget that latter point. My approach to both areas is quite structured. I assess, formulate the difficulty, then translate a solution into ideas which the individual client will understand. I usually use a whiteboard to go through this process.

Letters from America: A tale of two systems

Two British clinical psychologists, **Dr Jemma Rosen-Webb** and **Dr Shana Blair**, exchange letters reflecting on their moves to the USA, highlighting differences and similarities between the UK and USA and offering some pointers

Dear Shana,

It is now just over a year since I arrived in Cincinnati, Ohio. I have got my license to practice and am fortunate to have found a job that builds on my UK experience – working in early childhood.

I did lots of internet research before I arrived, but the path to licensure was still somewhat confusing. I eventually realised that each state has a psychology association and a licensing board – a bit like the UK situation with the BPS and the HPC. My state psychology association were very helpful in linking me up with people and giving me advice. I also joined a listserve hosted by the American Psychological Association (APA) for early career psychologists. I have learnt a lot through the regular questions, answers and comments that come through on those e-mails.

I found out that Ohio would not accept my supervised experience because a US psychologist had not supervised me. Luckily, Kentucky (just a 10-minute drive south) did accept my UK supervised practice. I was able to apply for a 'temporary license' with the State Licensing Board before I left the UK. I was fortunate to be a dual-citizen so I do not need a visa to work here.

Once I had my temporary license, I was authorised to take the computerised multiple-choice national exam, the Examination in the Professional Practice of Psychology (EPPP) and a state exam. I needed to pass both of these to obtain my 'independent license'. The EPPP is harder and more frustrating than you would think if you are used to being able to write essays to argue points rather than deciding on the 'right' answer. My state exam wasn't too bad and consisted of an oral vignette and a test on some state laws. I was lucky to have been put in touch with some other 'early career psychologists' who gave me helpful revision guides.

I passed those and am now independently licensed. In Kentucky that means that while there is no requirement for ongoing supervision, I must get outside supervision or consultation if I am working with an issue/client-group outside of my regular scope of practice. I chose to pay for supervision, however, in order to increase my chances of mobility to other states in the future and to help me acclimatise.

Five months after I got here, I was really excited to be offered a position as 'Early Childhood Mental Health Specialist' in a 'community mental health organisation'. These organisations predominately serve people who have some level of state or federal assistance with their health care (Medicaid, Medicare and local state programmes for kids) and are the closest you get to the NHS here. In Kentucky different community mental health organisations cover different geographical areas and so the whole state is covered. I'm not sure if that is the same in other states.

The main distinction between disciplines where I work is between 'therapist' and 'psychiatrist'. Although there are other distinctions (clinical social worker, marriage and family therapist, psychologist), we all get referred to as therapists. Cases are allocated based on availability and experience with that client/problem, and it is rare for cases to be transferred (e.g. for family work), unless the client has asked for a different therapist. Another difference is that there are rarely times when more than one therapist is working with a family in the same room (although you may have lots of different therapists involved with many different family members).

I have at times missed being around as many clinical psychologists as I was in my post in London (although being involved in my state psychology association has helped with this – I am on the Early Career Psychologist Committee).

My job is a mixture of consultation to daycares, training daycare workers and other therapists, and direct clinical work. On my clinical days it is expected that I book back-to-back clients throughout the day. I have 'billable hour expectations' to meet, i.e. hours spent in actual sessions. There is no official time for admin/making phone calls, and the assumption is that you will do that when one of your clients does not come. Only face-to-face time is billable.

Once we have done an assessment, we have to write a 'treatment plan' (this can be done any time up to the fourth session). We have some treatment plan templates that are diagnosis-specific and intended to outline best practice. Thereafter, following each session, a note must be made on which goals you addressed. Formulation is not a term people are familiar with, and things move directly from 'assessment' to 'treatment'. There is also the flexibility

I use CBT a lot, and I'm careful not to pathologise the client when I'm using clinical skills.'

Where does this slightly dual career lead? 'I like variety. I'm constantly getting asked to get involved in long-term projects with clubs and associations, and by taking up these it will reduce the variety of things I do. In the medium term, I'd like to split my time half and half between clinical and sports work. I suppose three things might affect this. I am increasingly requested to talk to the media, and I'm quite interested in developing this. I'm listed on the Society media list, and the opportunities that come up usually have short turn round times. Just like for a professional sportsperson, working for the media brings with it performance pressure and the potential for public scrutiny.

'Secondly, the NHS has changed and is becoming more focused on form-filling and less about seeing patients and delivering excellence. That's demotivating for staff, and I'm not convinced that it is that helpful for many patients.

'Finally, I do work with groups other than sports people. There is potential to extend the approach to other groups where performance under pressure is important. Dancers are an obvious example, but you can apply the ideas to others in the performing arts. Also, I've been asked to help city traders to improve their self-management of performance anxiety and to focus on the important elements of their work. Now it interests me to help figure out how psychology can help these client groups. So, I expect the next few years will see some changes – where I'll end up is less certain.'

to write your own treatment plan While treatment plans can feel constrictive and overly prescriptive, the idea of routinely having documented specific goals that must be reviewed at certain points (at least every six months in my agency) has been helpful.

I have come to realise that DSM seems to primarily exist for insurance companies (and Medicaid/Medicare which is state/federal insurance). When we see a client, the organisation bills individually for that client. Without a DSM code, the insurance company will not pay. Initial diagnoses are often based on one short face-to-face intake assessment. Therapists seem to vary in how broad or specific they make their initial diagnoses (e.g. using Disruptive Behaviour Disorder Not Otherwise Specified vs. an ADHD diagnosis). These are working diagnoses and can be changed with proper documentation as your work progresses.

In my organisation, therapists have their own offices where they have a desk and computer and also see clients. Child therapists offices are much more 'child friendly' than in the UK. There are more toys, beanbags and cushions, and therapists often put children's artwork on the walls. Seeing artwork on the walls when I first arrived made me think back to the service-related research I did during my training on children's experiences of coming to a CAMHS service. They suggested having artwork on the walls, but a team meeting decided confidentiality precluded this.

I have learnt that community mental health organisations are overseen by regulating bodies who have many requirements about how files should be kept, what assessment information should be gathered, how paperwork should look, etc. Files are regularly reviewed both internally and externally. This is something that I remember happening to some extent in the NHS prior to my leaving, but which seems to occur much more frequently here.

One big surprise is how few employment laws there are in the US. Some of the things we think of as 'fair work conditions', Americans consider as benefits. The rumoured 'they only get two weeks annual leave' is fairly accurate. I get nearly three weeks and an extra week once I have worked here for 18 months. Annual leave is accrued every two weeks and sick leave seems to be managed differently by different organisations. This is an issue America-wide, and I have met clients who have lost their jobs due to sickness and had to move across the country to live back with family. Other parents have had to leave their jobs for taking too much time off to take their kids to appointments. Flexible working doesn't really seem to exist here, and it seems a lot harder for working parents with children.

So how are things going with you?

Jemma

Dear Jemma

How nice to hear from you! I've finally traversed the US immigration and visa ordeal and have spent the past eight months settling into life and work in Virginia (VA).

I'm still pursuing the license to practice psychology here. After several months of persistent communication between the state board and my previous academic institutions and past supervisors, I have finally been given the go-ahead to sit the EPPP! I have recently passed the VA state exam, which wasn't really too bad and am now in the process of ploughing through the examination prep materials for the national exam. I completely connect with the frustration you described about the multiple-choice format, especially when we're so used to being able to discuss and deconstruct a point!

However, this positivistic approach has equipped me to navigate working life within the state-/Medicaid-funded community mental health agency I've been employed within for the past six months as a 'mental health therapist'. It seems that most of the opportunities to work as a 'clinical psychologist' are limited to the private or academic sectors. The agency I work for sounds very similar to the organisation and encounters you've described, although I'm working with a different client population (adults affected by severe mental health problems). The extent of social deprivation I've witnessed working with the agency, which primarily addresses the needs of those that have no health insurance, housing or recourse to other public assistance due to unemployment and long histories of mental health difficulties, has been eye-opening and has certainly furnished me with a new perspective of the NHS and UK public assistance system. The pervasiveness of DSM nomenclature, which so evidently influences all areas of clinical and non-clinical activities (including the incredible amount of paperwork necessary to document and bill for client-related contacts), has been a challenging pill to swallow – and Geez, the amount of pills available to swallow sure is amazing! I've been struck by the extent of clinical activity that's dictated by (mis-)diagnosis, which I have come to learn so much more about: making regular use of all five axes! I can't help but think about what our dear old clinical director would have to say...

My biggest challenge by far, especially with a young, expanding family, are the employment and healthcare benefit systems. It pains to me say that I am also coming to terms with the minimal leave (not only annual, but also sick and maternity leave). I have also been struck by the 'employment-centric' organisation of everyday life over here, to the extent that all other aspects of life (e.g. healthcare, family life, etc.) are governed by employment status. As for the healthcare system, well, that deserves a follow-up letter... Look forward to catching up with you soon!

Shana

I *If anyone is thinking of making the move to the USA, Jemma and Shana say they would be happy to try and help you out (jemma76@gmail.com).*